MAIL TO: MANITOBA BLUE CROSS
P.O. BOX 1046, WINNIPEG, R3C 2X7

UNIVERSITY OF MANITOBA DENTAL PLAN
DENTAL CLAIM FORM

Reset Form

DATE RECEIVED

DENTIST

DENTIST NO. | DENTIST NAME

DENTIST ADDRESS

CITY/PROVINCE | POSTAL CODE

SERVICES FOR BENEFITS HAVE BEEN

☐ PERFORMED ☐ PLANNED

PRE-AUTHORIZATION REQUIRED FOR ALL ACCOUNTS $500.00 OR MORE.

COVERAGE

Full-Time Staff

Basic Services 80%
Major Services 60%

Orthodontic Services 50%

FOR DEPENDENT CHILDREN ONLY, TO THEIR 19TH BIRTHDAY, PROVIDED THAT BRACES WERE PLACED PRIOR TO THEIR 18TH BIRTHDAY.

Part-Time Staff

Basic Services 50%
Major Services 50%

Orthodontic Services 50%

FOR DEPENDENT CHILDREN ONLY, TO THEIR 19TH BIRTHDAY, PROVIDED THAT BRACES WERE PLACED PRIOR TO THEIR 18TH BIRTHDAY.

ELIGIBLE DEPENDENTS

THE STAFF MEMBER'S **SPOUSE** AND ANY **UNMARRIED CHILD** WHO **NORMALLY RESIDE** WITH THE STAFF MEMBER OR THE OTHER PARENT AT HIS/HER REGULAR RESIDENCE.

SPOUSE – THE STAFF MEMBER'S LEGAL SPOUSE, COMMON-LAW SPOUSE OR SAME-SEX PARTNER (COMMON-LAW SPOUSE OR SAME-SEX PARTNER MEANS THE INDIVIDUAL WHO HAS BEEN RESIDING WITH THE STAFF MEMBER IN A CONJUGAL RELATIONSHIP FOR A PERIOD OF NOT LESS THAN ONE YEAR.)

CHILD – ANY UNMARRIED NATURAL CHILD, ADOPTED CHILD OR STEP-CHILD OF THE STAFF MEMBER OR THE INSURED SPOUSE AND INCLUDES ANY CHILD FOR WHOM THE STAFF MEMBER OR THE INSURED SPOUSE HAS BEEN APPOINTED LEGAL GUARDIAN BY A COURT OF COMPETENT JURISDICTION PROVIDED SATISFACTORY PROOF OF SUCH GUARDIANSHIP IS PROVIDED TO THE INSURER.

i) FROM BIRTH BUT UNDER 21 YEARS OF AGE, A CHILD UNDER AGE 21 MUST NOT BE WORKING MORE THAN 30 HOURS A WEEK.

ii) UP TO 25 YEARS OF AGE, IF A FULL-TIME STUDENT AT A SCHOOL, COLLEGE OR UNIVERSITY;

iii) 21 YEARS OF AGE OR OVER, BUT CONTINUES TO BE INCAPABLE OF SELF-SUSTAINING EMPLOYMENT BY REASON OF MENTAL OR PHYSICAL HANDICAP.

A CHILD OF THE INSURED SPOUSE IS NOT INSURABLE UNLESS: HE/SHE IS ALSO THE EMPLOYEE'S CHILD OR THE SPOUSE IS LIVING WITH THE STAFF MEMBER AND HAS CUSTODY OF THE CHILD.

A CHILD FOR WHOM THE STAFF MEMBER OR THE INSURED SPOUSE HAS BEEN APPOINTED GUARDIAN IS NOT INSURABLE UNLESS SATISFACTORY PROOF OF GUARDIANSHIP IS PROVIDED AND IF THE INSURED SPOUSE IS THE GUARDIAN, THE SPOUSE IS LIVING WITH THE STAFF MEMBER.

STAFF MEMBER

STAFF MEMBER INFORMATION — COMPLETE IN FULL

FULL-TIME ☐
PART-TIME ☐

EMPLOYEE NUMBER: 8

GROUP NUMBER: 67000

SURNAME | FIRST NAME

ADDRESS

CITY, PROVINCE | POSTAL CODE

HAS YOUR ADDRESS CHANGED IN THE PAST 12 MONTHS? ☐ YES ☐ NO

PHONE HOME OFFICE

PATIENT INFORMATION MUST BE GIVEN
PATIENT'S FIRST NAME

BIRTH DATE: MON. | YEAR

RELATIONSHIP TO STAFF MEMBER
☐ SELF ☐ SPOUSE ☐ DEPENDENT

IF CHILD OVER AGE 18, INDICATE SCHOOL ATTENDED

IS TREATMENT REQUIRED AS A RESULT OF ACCIDENT?

☐ YES ☐ NO IF YES, GIVE DETAILS

ARE DENTAL BENEFITS PROVIDED UNDER ANY OTHER INSURANCE OR DENTAL PLAN?

☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING

PERSON INSURED UNDER OTHER PLAN _____

EMPLOYER _____

EMPLOYER'S INSURANCE COMPANY _____

POLICY OR CONTRACT NUMBER _____

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE COST OF THE TREATMENT. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MANITOBA BLUE CROSS. I CERTIFY THAT I AM A STAFF MEMBER OF THE UNIVERSITY OF MANITOBA AND THAT THE SERVICES OUTLINED HEREIN ARE FOR MYSELF, OR MY ELIGIBLE DEPENDENT. I ALSO CERTIFY THAT I AM AN ELIGIBLE STAFF MEMBER OF THE UNIVERSITY OF MANITOBA STAFF MEMBER DENTAL PLAN, AND THAT THE INFORMATION CONTAINED IN THIS FORM IS COMPLETE AND ACCURATE.

SIGNATURE OF ELIGIBLE STAFF MEMBER _____

PLAN BENEFITS CANNOT BE ASSIGNED TO DENTISTS.
BENEFITS WILL BE PAID DIRECTLY TO STAFF MEMBERS.

3 - DENTIST — Examination and Treatment Record

BLUE CROSS USE ONLY

SERVICES PERFOR. DAY	MON.	YR.	TOOTH CODE INT.NO.	PROCEDURE NUMBER	SPECIFIC SURFACES FILLED	SERVICE MATERIAL	QTY. OR UNITS	AMOUNT BILLED	BLUE CROSS PAYS	REJECT REASON
								$	$	

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE ARE CORRECT AND REPRESENT THOSE RENDERED TO THE PATIENT NAMED.

DENTIST'S SIGNATURE _____ DATE: _____

NOTE: •STAFF MEMBER SECTIONS TO BE COMPLETED BY STAFF MEMBER AND MUST BE SIGNED.
• DENTIST SECTION TO BE COMPLETED BY DENTIST.

MANITOBA BLUE CROSS™

MBC 1020-15M-04/2002