Assignment of Benefits

Affinity Markets Health Claims
Manulife Financial
PO Box 4214, Stn A
Toronto ON M5W 5M4

Manulife Financial

IMPORTANT NOTE: **Complete this form only when assigning benefits to the Provider.**
A separate Assignment of Benefits form must be completed for each Provider.

PLEASE PRINT CLEARLY

PROVIDER INFORMATION		PLAN MEMBER INFORMATION	
Provider's Name		**Plan Member's Name**	
Address	**City**	**Address**	**City**
Province	**Postal Code**	**Province**	**Postal Code**
Provider Registration Number		**Plan Member I.D. Number**	
Provider's Signature or Official Stamp	**Date (D/M/Y)**	**Group/Policy Number**	

AUTHORIZATION

I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to the service provider for the entire cost associated with this claim. I hereby assign my benefits payable from this claim to the named service provider and authorize payment directly to them.

I understand that Manulife Financial and/or a Benefit Plan Sponsor reserve the right to modify assignment privileges for specific benefits, benefit categories, specific service providers or service provider categories.

I/We hereby certify that the information provided in connection with this claim is true, accurate and complete. I/We hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, pre-payment organization, insurance company, third party administrator, plan sponsor, employer, government agency, investigative or security agency or any other person or organization having any records, knowledge or information concerning this claim or my/our health or the health of any insured member of my/our family as it may relate to this claim to release such information to Manulife Financial to exchange such information with any of the named parties where such exchange is necessary for the proper adjudication and processing of the claim. A photocopy of this signed authorization shall be as valid as the original.

Plan Member's Signature **Date (D/M/Y)**