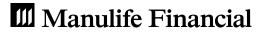
Assignment of Benefits
Affinity Markets Health Claims
Manulife Financial
PO Box 4214, Stn A
Toronto ON M5W 5M4



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	
	AUTHOR	IZATION	
I understand that the fees listed in this claim n responsible to the service provider for the entire named service provider and authorize payment	cost associated with th	or may exceed my plan benefits. I under its claim. I hereby assign my benefits pa	erstand that I am financially ayable from this claim to the
I understand that Manulife Financial and/or a B benefit categories, specific service providers or			vileges for specific benefits,
I/We hereby certify that the information provid- licensed physician, medical practitioner, hos- insurance company, third party administrator, person or organization having any records, kno member of my/our family as it may relate to t with any of the named parties where such exc of this signed authorization shall be as valid	spital, pharmacy, clini plan sponsor, employe wledge or information this claim to release su hange is necessary for	ic or other medically related facility, r, government agency, investigative or s concerning this claim or my/our health ch information to Manulife Financial to	pre-payment organization, security agency or any other or the health of any insured exchange such information
Plan Member's Signature		Date (D/M/Y)	

MF.EHP108B (rev.12/04)