



STANDARD DENTAL CLAIM FORM

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POLICY NO SPOUSE DATE OF BIRTH SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER PART 4 POLICY HOLDER/EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE. SEE ABOVE*)	INSTRUCTIONS FOR CLAIM SUBMISSION BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT, YOUR CERTIFICATE OR FROM YOUR EMPLOYER. IF YOUR PLAN REQUIRES SUBMISSION DIRECTLY TO THE CARRIER, PLEASE SEND THIS FORM WITH ONLY PARTS 1, 2*IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OF PART 2 - EMPLOYEE/PLAN MEMBER/SUBSCRIBER 1. GROUP POLICY/PLAN NO	AND 3 COMPLETED TO THE CARRIER'S APPROPRIATE CLAIMS OFFICE. CCE/PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER. 2. YOUR NAME (PLEASE PRINT)
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DAY MONTH YEAR DATE	INSTRUCTIONS FOR CLAIM SUBMISSION BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT, YOUR CERTIFICATE OR FROM YOUR EMPLOYER. IF YOUR PLAN REQUIRES SUBMISSION DIRECTLY TO THE CARRIER, PLEASE SEND THIS FORM WITH ONLY PARTS 1, 2 "IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OF PART 2 - EMPLOYEE/PLAN MEMBER/SUBSCRIBER 1. GROUP POLICY/PLAN NO	AND 3 COMPLETED TO THE CARRIER'S APPROPRIATE CLAIMS OFFICE. CE/PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER. 2. YOUR NAME (PLEASE PRINT)
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1. DATE COVERAGE COMMENCED 4. CONTRACT HOLDER AUTHORIZED SIGNATURE	INSTRUCTIONS FOR CLAIM SUBMISSION BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT, YOUR CERTIFICATE OR FROM YOUR EMPLOYER. IF YOUR PLAN REQUIRES SUBMISSION DIRECTLY TO THE CARRIER, PLEASE SEND THIS FORM WITH ONLY PARTS 1, 2*IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OF PART 2 - EMPLOYEE/PLAN MEMBER/SUBSCRIBER 1. GROUP POLICY/PLAN NO	AND 3 COMPLETED TO THE CARRIER'S APPROPRIATE CLAIMS OFFICE. CE/PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER. 2. YOUR NAME (PLEASE PRINT) YOUR CERT. NO. OR I.D. NO. YOUR DATE OF BIRTH DAY MONTH YEAR 3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? NO YES IF YES, GIVE DATE AND DETAILS SEPERATELY. 4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? NO YES GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT. NO YES 5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? NO YES 6. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER / PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE. DATE DATE DATE DAY MONTH YEAR SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER
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3. DATE TERMINATED (POSITION OR TITLE)	INSTRUCTIONS FOR CLAIM SUBMISSION BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT, YOUR CERTIFICATE OR FROM YOUR EMPLOYER. IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM WITH ONLY PARTS 1, 2° IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OF PART 2 - EMPLOYEE/PLAN MEMBER/SUBSCRIBER 1. GROUP POLICY/PLAN NO	AND 3 COMPLETED TO THE CARRIER'S APPROPRIATE CLAIMS OFFICE. CE/PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER. 2. YOUR NAME (PLEASE PRINT)