INFORMATION ABOUT YOUR INSURANCE BENEFITS

To help you understand your insurance coverage, we require the following information from your Employer or Insurance Company:

Your Name (according to insurance company); _____
Responsible Party _____
Responsible Party Birth date; _____
SI.N. _____
Employer; _____
Employer Telephone; (___) _____
Insurance Carrier; _____
Carrier Telephone; (___) _____
Address of Carrier; Street_____ City_____
Prov_____ PC_____
Policy # _____
Division# _____
Certificate # _____
Yearly Maximum $_____
Deductible $ _____
Fee guide used? _____
What is the calendar year? _____
Is there crown and bridge coverage? Yes No
Is there denture coverage? Yes No
If applicable- how often can dentures be replaced?
Is there ortho coverage? Yes No Lifetime Max? $_____
What percentage does your plan cover?
Basic work: _____ % Major Work _____%
Are recall every six or nine months? _____
How many units of scaling are covered per year: _____
Dependents covered; _____
_____

Mail Claims to _____

Mail Authorizations to _____

Remarks

_____
_____
_____
_____