DENTAL INSURANCE INFORMATION

IF YOU HAVE DENTAL INSURANCE PLEASE COMPLETE THE FOLLOWING…

Name of insured ____

Relationship to insured ____

Insured's place of employment ____________________________________

Insured's date of birth ____

Name of insurance company _______________________________________

Group number ____

Identification number ____

Division number ____

Authorization to submit insurance claim electronically

Signature ____________________________________

****Please note that we can only submit to one insurance company through our computer. If you have dual coverage we will give you a second claim for you to fill out and mail away manually.*

Please check if you have dual coverage and need a second insurance form.

Yes ______________ *No* _________________