

**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* \_\_\_\_\_