ATTENDING DENTIST'S STATEMENT

CHECK ONE:

☐ DENTIST'S PRE-TREATMENT ESTIMATE

☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

EMPLOYEE'S SELF-FUNDING BENEFITS DENTAL CLAIM FORM

MAIL TO
Associated Life Underwriters
P.O. Box 400
Meadville, PA 16335-0400
Toll Free (800) 258-8533
Phone Number (814) 724-1900

PART I — TO BE COMPLETED BY EMPLOYEE

1. PATIENT NAME
2. RELATIONSHIP — SELF | SPOUSE | CHILD | OTHER
3. SEX — M | F
4. PATIENT DOB — MO | DAY | YEAR
5. IF FULL TIME STUDENT — SCHOOL:
6. EMPLOYEE NAME — FIRST MIDDLE LAST
7. EMPLOYEE SOCIAL SECURITY NO
8. EMPLOYER (COMPANY) NAME
9. EMPLOYEE MAILING ADDRESS
10. EMPLOYEE DOB — MO | DAY | YEAR
11. EMPLOYER ADDRESS
CITY, STATE, ZIP
12. GROUP - DIVISION NUMBERS
13. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO
14. IF YES, SUBSCRIBER'S DOB — MO | DAY | YEAR
15. PATIENT'S RELATIONSHIP TO SUBSCRIBER — SELF | SPOUSE | CHILD | OTHER

PLEASE NOTE: FAILURE TO COMPLETE PART I IN FULL (INCLUDING GROUP, DIVISION AND SOCIAL SECURITY NUMBERS) MAY RESULT IN PROCESSING DELAYS.

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

SIGNED (PATIENT OR PARENT IF MINOR) DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

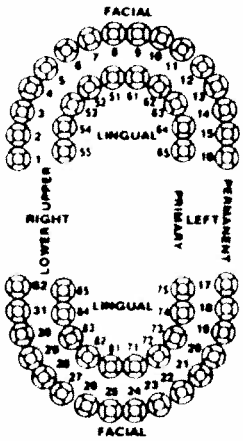
SIGNED (INSURED PERSON) DATE

PART II — TO BE COMPLETED BY ATTENDING DENTIST

16. DENTIST NAME
17. MAILING ADDRESS
CITY, STATE, ZIP
18. DENTIST SOC. SEC. OR T.I.N.
19. DENTIST LICENSE NO.
20. DENTIST PHONE NO.
21. FIRST VISIT DATE CURRENT SERIES
22. PLACE OF TREATMENT — OFFICE | HOSP. | ECF | OTHER
23. RADIOGRAPHS OR MODELS ENCLOSED? NO | YES | HOW MANY?

	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
26. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
28. IF PROSTHESIS IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) 29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER: DATE APPLIANCES PLACED; MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



31. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN.

TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO DAY YEAR	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY

32. REMARKS FOR UNUSUAL SERVICES

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.

SIGNED (DENTIST) DATE

TOTAL FEE CHARGED

Please note. Pretreatment Review is not a guarantee of benefits payable.