



# CLAIM FORM

## Group Dental Benefit

### For Administrators Use Only

Employer Code		Month	Day	Year
Effective Date Employee's Coverage				
Effective Date Patient's Coverage				
Date of Employment				
Is this a Workers Compensation Claim?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Date	Signature			

### SECTION I To Be Completed By Employee Or Member

Name, in Full, of Employee or Member		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Your Social Security No.
Name of Patient		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	First Name of Spouse Spouse's Social Security No.
Is Patient: Yourself <input type="checkbox"/>	Your Spouse <input type="checkbox"/> (Check One)	Is Patient: Single <input type="checkbox"/>	Married <input type="checkbox"/> (Check One)	Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Your Child <input type="checkbox"/>	Other <input type="checkbox"/>	Divorced <input type="checkbox"/>	Legally Separated <input type="checkbox"/>	If "Yes," Name and Address of Employer
Explain:				
If patient is child, is he or she employed? <input type="checkbox"/> Yes <input type="checkbox"/> No.		If "Yes," Name and Address of Employer		

Is patient covered through any other plans (including "NO FAULT" auto insurance) which provide medical or dental benefits or services? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes," list all other insurance companies or service plans providing this coverage. Name Address	Through what Employers or Organizations are plans provided, if other than previously stated? Name Address
Identify TYPE of Other Coverage: <input type="checkbox"/> Group — Policy No.	Cert. No. <input type="checkbox"/> Individual
<input type="checkbox"/> Blue Cross	<input type="checkbox"/> Other Specify
<input type="checkbox"/> Blue Shield — Contract No.	Cert. No.

Was dental treatment required because of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	When did accident happen? Date: _____ Hour: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
Describe injuries received	If treatment was for injury, was accident caused by patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of attending dentist	

We certify that the foregoing statements and answers are true and complete to the best of our knowledge and belief.

We hereby agree to reimburse the Graphic Arts Benefit Corporation to the extent of the amount paid on this claim under any non-occupational policy provision in the event benefits are provided under any Workmen's Compensation law or similar legislation.

We hereby authorize any insurance company, prepayment organization, employer, union, trust fund, hospital, or physician to release all information with respect to us or any of our dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy of this authorization shall be considered as effective and valid as the original.

Date	Signature of Employee or Member	Signature of Spouse
Mailing Address	Street	City State Zip Code

**Note:**  
**This Form should be submitted to your Dentist PRIOR to treatment for which you expect the charges to be excess of \$500.00.**

#### CLAIM INSTRUCTIONS FOR EMPLOYEE AND DENTIST

1. Employee Complete Section I above and Section II on reverse side.
2. Attending Dentist complete Section III on reverse side.
3. Claim form and all applicable bills should then be sent to:



