
INSTRUCTIONS FOR MEMBER

Please be sure that you complete ALL of the information in Section I on the front of this form.

NOTE:

- BOX 11 - If you or the patient is covered by any other group dental insurance policy, please provide us with the name of the insurance company, address and policy number(s).
- BOX 13 - Please be sure to check either yes or no to parts A and B.
- BOX 14 - If the patient's dental treatment is the result of an accident, please provide us with the date of the accident, place of the accident and a description of the accident.
- BOX 15 - Please be sure to sign this box for the release of any information.
- BOX 16 - Only sign this box if you want benefits paid directly to the dentist. Do not sign this box if you want benefits paid to you.