Dental Claim Statement

* Required Field

ASSURANT Employee Benefits

Check one:
☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services

Carrier name and address:
Assurant Employee Benefits, PO Box 2940, Clinton, IA 52733-2940
T 800.442.7742

PATIENT COVERAGE INFORMATION

1 Patient name * First M.I. Last

2 Relationship to employee ☐ Self ☐ Child ☐ Spouse ☐ Other _____

3 Sex M F

4 Patient birthdate MO DAY YR

5 If full-time student School City

6 Employee/subscriber name and mailing address

7 Employee/subscriber Soc. Sec. or I.D. no.

8 Employee/subscriber birthdate MO DAY YR

9 Employer (company) name and address

10 Group number

11 Is patient covered by another dental plan? ☐ Yes ☐ No
If "Yes," complete 12-a.
Is patient covered by a medical plan? ☐ Yes ☐ No

12-a Name and address of carrier(s)

12-b Group no(s).

13 Name and address of other employer(s)

14-a Employee/subscriber name *(if different than patient's)*

14-b Employee/subscriber Soc. Sec. or I.D. no.

14-c Employee/subscriber birthdate MO DAY YR

15 Relationship to patient ☐ Self ☐ Parent ☐ Spouse ☐ Other _____

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.) This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

▶ SIGNED (PATIENT OR PARENT, IF MINOR) DATE

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named entity.

▶ SIGNED (INSURED PERSON) DATE

BILLING DENTIST

16 Name of Billing Dentist or Dental Entity

17 Address where payment should be remitted

City, State, Zip

18 Dentist Soc. Sec. or TIN

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?

24 Is treatment result of occupational illness or injury? No Yes If "Yes," enter brief description and dates.

25 Is treatment result of auto accident? No Yes

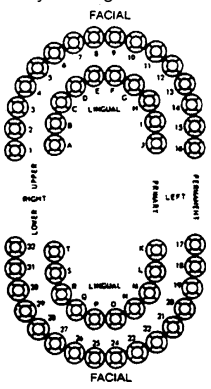
26 Other accident? No Yes

27 If prosthesis, is this initial placement? No Yes If "No," reason for replacement

28 Date of prior placement

29 Is treatment for orthodontics? No Yes If services already commenced, enter Date appliances placed Mos. treatment remaining

Identify missing teeth with "**X**"



30 Examination and treatment plan—List in order from tooth no. 1 through tooth no. 32—Use charting system shown.

Tooth # or letter	Surface	Description of Service *(including x-rays, prophylaxis, materials used, etc.)*	Date Service Performed Mo Day Year	Procedure Number	Fee

31 Remarks for unusual services

For administrative use only

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

SIGNED (TREATING DENTIST) LICENSE NUMBER DATE

Total Fee Charged	
Max. allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

A pre-treatment estimate is recommended for non-emergency treatment plans to forewarn a claimant if a certain item or service has limited or no coverage available.

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company.

KC2147A (5/2006)

☞ **If you live in the state of Arizona, the following statement applies to you:**
For your protection Arizona Law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

☞ **If you live in the states of Arkansas, Louisiana or Texas, the following statement applies to you:**
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

☞ **If you live in the state of California, the following statement applies to you:**
For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

☞ **If you live in the state of Colorado, the following statement applies to you:**
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

☞ **If you live in the District of Columbia, the following statement applies to you:**
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

☞ **If you live in the state of Florida, the following statement applies to you:**
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

☞ **If you live in the state of New Jersey, the following statement applies to you:**
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

☞ **If you live in the state of New York, the following statement applies to you:**
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

☞ **If you live in the state of Oregon, the following statement applies to you:**
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

☞ **If you live in a state other than mentioned above, the following statement applies to you:**
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.