DENTAL BENEFITS:

PRIMARY DENTAL BENEFITS:

INSURANCE COMPANY: _____

EMPLOYEE NAME: _____

PLAN HOLDERS DATE OF BIRTH (mm/dd/yyyy): ____/____/____

RELATIONSHIP TO PLAN HOLDER: _____

GROUP/PLAN NUMBER: _____DIV: _____

ID/CERTIFICATE NUMBER: _____

SECONDARY DENTAL BENEFITS:

INSURANCE COMPANY: _____

EMPLOYEE NAME: _____

PLAN HOLDERS DATE OF BIRTH (mm/dd/yyyy): ____/____/____

RELATIONSHIP TO PLAN HOLDER: _____

GROUP/PLAN NUMBER: _____DIV: _____

ID/CERTIFICATE NUMBER: _____

PLAN DETAILS:

PLEASE BRING YOUR BENEFIT DETAILS/PLAN BREAKDOWN TO YOUR FIRST APPOINTMENT SO WE WILL BE ABLE TO WORK DIRECTLY WITH YOUR BENEFIT PLAN. IF YOU ARE UNABLE TO BRING YOUR BENEFIT DETAILS/PLAN BREAKDOWN TO YOUR FIRST APPOINTMENT, WE WILL ASK YOU FOR PAYMENT AND OUR BUSINESS TEAM WILL BE HAPPY TO SUBMIT TO YOUR BENEFIT PLAN ON YOUR BEHALF, TO REIMBURSE YOU DIRECTLY.