BROKERS NATIONAL
LIFE ASSURANCE COMPANY

P.O. Box 1028
Houston, TX 77251-1028
800-653-4427

CHECK ONE:
☐ PRE DETERMINATION ESTIMATE
☐ STATEMENT OF ACTUAL SERVICES

DENTAL CLAIM NOTICE

PART 1 EMPLOYEE - READ INSTRUCTIONS CAREFULLY BEFORE YOU COMPLETE

1. PATIENT NAME
2. PATIENT RELATIONSHIP TO EMPLOYEE: SELF | SPOUSE | CHILD | OTHER
3. SEX: M | F
4. PATIENT BIRTHDATE: MO | DAY | YEAR
5. IF FULL TIME STUDENT NAME OF SCHOOL — CITY
6. EMPLOYEE NAME: FIRST — MIDDLE — LAST
7. EMPLOYEE SOCIAL SECURITY NO.
9. EMPLOYEE MAILING ADDRESS
CITY, STATE, ZIP
10. EMPLOYER (COMPANY) NAME AND ADDRESS
11. GROUP NUMBER
12. ARE OTHER FAMILY MEMBERS EMPLOYED? ☐ YES ☐ NO
If Yes give EMPLOYEE NAME — SOCIAL SECURITY NO.
13. NAME AND ADDRESS OF EMPLOYER IN ITEM 12.
14. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO IF YES GIVE: DENTAL CARRIER — GROUP NO. — PHONE NO. AND ADDRESS OF CARRIER

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

SIGNED (PATIENT, OR PARENT IF MINOR) ____________ DATE ______

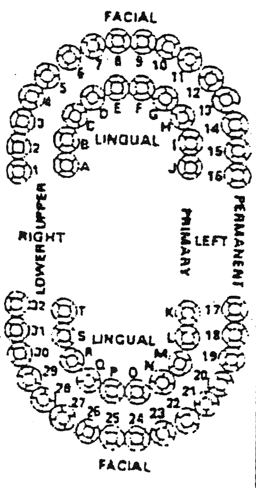
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE DENTAL PLAN BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED (EMPLOYEE) ____________ DATE ______

PART 2 - DENTIST READ INSTRUCTIONS CAREFULLY BEFORE YOU COMPLETE

15. DENTIST NAME
16. MAILING ADDRESS
17. CITY, STATE, ZIP
18. DENTIST SOC SEC OR T I N NO
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 SERVICES RELATED TO TMJ?			
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



INDICATE MISSING TEETH WITH AN X

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

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO DAY YEAR	ADA PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY TYPE SERVICE I	II	III
				TOTAL FEE	$			

32. REMARKS FOR UNUSUAL SERVICES

PART 4

I HEREBY CERTIFY THAT SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE NAMED PATIENT ON THE DATES INDICATED AND THAT THE FEES SHOWN ARE THOSE CURRENTLY CHARGED TO THE MAJORITY OF MY PATIENTS.

SIGNED (DENTIST) ____________ DATE ______

MUST BE FURNISHED UNDER AUTHORITY OF LAW WHEN BENEFITS ASSIGNED.

PART 3

THE PLAN BENEFITS INDICATED WILL BE PAYABLE IF THE SERVICES LISTED ABOVE ARE PERFORMED WHILE THE PATIENT IS COVERED UNDER THIS PLAN, SUBJECT TO THE COORDINATION OF BENEFITS WITH OTHER PLANS.

IL-GA-1704 (08/91)

INSTRUCTIONS FOR FILING DENTAL CLAIMS

INSTRUCTIONS TO EMPLOYEE:

Complete Part 1 in full (please type or print)
Incomplete information may delay servicing of your claim

Give this form to your dentist after you have completed Part 1

If services will exceed $300 you may request your dentist to submit a Pre-Determination Estimate to the Claim Department. The Claim Department will advise your dentist and yourself what the Plan will pay.

INSTRUCTIONS TO DENTISTS OFFICE:

Complete the Dentists portion of the claim form.

Have the employee sign the payment authorization block if payment is to be made directly to your office and forward original to the address shown on reverse.

If you are requesting a Pre-Determination of plan benefits, retain a copy of the Dental Claim Notice you have forwarded. Your office, and the employee will receive an explanation of benefits from the claim department. After the services have been performed, forward a copy of the Dental Claim Notice to the address shown on the reverse indicating the dates of service and any changes in the services originally reported.