BROKERS NATIONAL
LIFE ASSURANCE COMPANY

PO 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			10. EMPLOYER (COMPANY) NAME AND ADDRESS	
CITY, STATE, ZIP				
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.

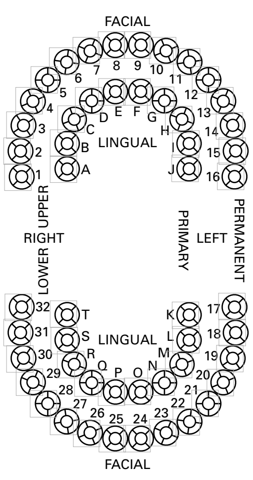
SIGNED (PATIENT OR PARENT IF MINOR) ________________ DATE ________

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	24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO ❒	YES ❒	IF YES, ENTER BRIEF DESCRIPTION AND DATES
16. MAILING ADDRESS	25. IS TREATMENT RESULT OF AUTO ACCIDENT?	❒	❒	
	26. OTHER ACCIDENT?	❒	❒	
17. CITY, STATE, ZIP	27. ARE SERVICES RELATED TO TMJ?	❒	❒	
18. DENTIST SOC SEC OR TIN NO. / 19. DENTIST LICENSE NO. / 20. DENTIST PHONE NO.	28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	❒	❒	(IF NO, REASON FOR REPLACEMENT) / 29. DATE OF PRIOR PLACEMENT
21. FIRST VISIT DATE CURRENT SERIES / 22. PLACE OF TREATMENT: OFFICE ❒ HOSP ❒ ECF ❒ OTHER ❒ / 23. RADIOGRAPHS OR MODELS ENCLOSED? NO ❒ YES ❒ HOW MANY?	30. IS TREATMENT FOR ORTHODONTICS?	❒	❒	IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED / MOS. TREATMENT REMAINING



INDICATE MISSING TEETH WITH AN X

32. REMARKS FOR UNUSUAL SERVICES

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 PREFORMED MO DAY YEAR	ADA PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY – TYPE SERVICE I	II	III

TOTAL FEE $

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 ________

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.

MUST BE FURNISHED UNDER AUTHORITY OF LAW WHEN BENEFITS ASSIGNED.

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.