

STATEMENT OF CLAIM — DENTAL

GROUP & PENSION ADMINISTRATORS, INC.

P O Box 749075
 Dallas, Texas 75374-9075

PART A — Employee Information

1. Employee's name (first, middle, last)		2. Sex <input type="checkbox"/> M <input type="checkbox"/> F	3. Birthdate	4. Social Security Number
5. Home Address (street, city, state, zip)				6. Are you: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed

PART B — Patient Information and Authorization to Release Information

7. Claim is for: <input type="checkbox"/> Self <i>If "Self", skip to question 12.</i> <input type="checkbox"/> Spouse <input type="checkbox"/> Unmarried Dependent child		8. Patient's name		9. Sex <input type="checkbox"/> M <input type="checkbox"/> F	10. Birthdate
11. Employee, answer only for claims on unmarried dependent child: Name & address of school: Is child, age 19 or older, fully dependent on you for principal support and a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No Are natural parents divorced or separated? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have custody of the child? <input type="checkbox"/> Yes <input type="checkbox"/> No Does natural parent without custody have financial responsibility for health expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No Is your dependent covered by any other group insurance, prepaid health plan, Medicare or other governmental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, complete question 20.</i>					
12. Did claim result from accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		13. If "Accident", please provide date, place, and how it happened in spaces below: Date _____ Place _____ How did it happen? _____			
14. Was accident work related? <input type="checkbox"/> Yes <input type="checkbox"/> No					
15. Have you or the patient received any discount, credit or reduction on any of the expenses submitted? <input type="checkbox"/> Yes <input type="checkbox"/> No		16. Was patient totally disabled? If "Yes", give dates. From: _____ Thru: _____		17. Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", complete question 18.</i>	
18. Name of spouse		Birthdate	Social Security Number	Name, Address and Phone Number of Spouse's Employer	
19. Are you or your spouse, covered by any other group insurance, prepaid health plan, Medicare, or other governmental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", complete question 20.</i>					
20. Insured's Name		Group insurance company or plan's name			
Certificate number	Policy number	Group insurance company or plan's address (street, city, state, zip)			
<p>21. AUTHORIZATION TO RELEASE INFORMATION</p> <p>I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, employer or third party administrator having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents and any other non-medical information of me or my dependents to give to my employer, third party administrator, or its plan administrator, Group & Pension Administrators, Inc. or its legal representative, any and all such information.</p> <p>I UNDERSTAND information obtained with this Authorization will be used by Group & Pension Administrators, Inc. to determine eligibility for coverage, and eligibility for benefits under an existing plan. Any information obtained will not be released by Group & Pension Administrators, Inc. to any person or organization except to the plan administrator, my employer, third party administrator, reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required or as I may authorize. I KNOW that I may request to receive a copy of this Authorization.</p> <p>I AGREE that a photographic copy of this Authorization shall be as valid as the original. I AGREE this Authorization shall be valid for two and one half years from the date shown below, or for the duration of this claim, if longer.</p> <p>NOTICE TO FLORIDA RESIDENTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of third degree.</p>					
Date	Employee's signature			Spouse's signature (for dependent claims only)	

PART C — Employer Information

22. Plan No.	23. Employer No.	24. Employer Name
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