DENTAL
GROUP CLAIM FORM

Group Claim Office / P.O. Box 82510, Lincoln, NE 68501
Toll Free No.: 800-497-7044

RELIANCE STANDARD
Life Insurance Company
a DELPHI company

PART 1 - TO BE COMPLETED BY EMPLOYEE

1. Patient's Full Name (First, Middle Initial, Last)

2. Relationship to Employee: Self | Spouse | Child | Other

3. Sex: M | F

4. Patient Birthdate: Mo. | Day | Year

5. Employee's Full Name (First, Middle Initial, Last)

Employee's Birthdate: Mo. | Day | Year

6. Employee's and Claimant's Social Security Numbers

7. Employee's Mailing Address (Street, City, Zip)

Street or P.O. Box_____

City, State, Zip _____

Email _____

8. THIS SECTION MUST BE COMPLETED WITH ***EACH*** CLAIM SUBMISSION ***ONLY*** IF THE CLAIM IS FOR A DEPENDENT CHILD AGE 19 OR OVER.

Is patient a full time student? ❑ Yes ❑ No

If yes, Name of School _____

Address of School _____

9. Employer (Company) Name and Address

10. Group No. | Div. No. | Cert. No.

QUESTIONS 11. AND 12. MUST BE COMPLETED WITH EACH CLAIM SUBMISSION

11. Is patient covered by another dental plan? ❑ Yes ❑ No If yes, Employer / Plan Name _____ Policy Number _____

Name and Address of Insurance Carrier _____

12. Are other family members employed? ❑ Yes ❑ No If yes, please complete the following information for the individual that is employed:

Name:	Relationship	Date of Birth (Mo. Day Year)	Social Security Number	Name and Address of Employer:
	❑ Spouse ❑ Child			

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 cost of dental treatment. I certify these statements to be true and complete to the best of my knowledge.

Signed (Patient, or parent if minor) _____ Date _____

I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

Signed (Insured Person) _____ Date _____

FOR YOUR PROTECTION, ARIZONA LAW, CALIFORNIA LAW, AND THE LAWS OF OTHER STATES REQUIRE THE FOLLOWING STATEMENT TO APPEAR ON THIS FORM: It is fraudulent to fill out this form with information you know to be false or to knowingly omit facts which may have a bearing on the benefits for which you are applying. Criminal and / or civil penalties can result from such acts.

PART 2 - TO BE COMPLETED BY ATTENDING DENTIST - Please provide ADA Procedure Number to ensure accurate benefit determination.

Name of Patient:

Name of Insured Person:

16. Dentist Name and 17. Mailing Address

Specialist Designation: _____

Email: _____ Fax: _____

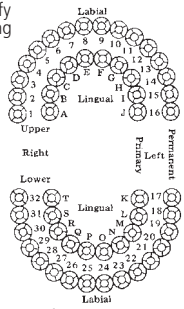
18. Dentist Soc. Sec. or TIN | 19. Dentist License # | 20. Dentist Phone #

21. First Visit Date Current Series | 22. Place of Treatment: Office | Hosp | ECF | Other | 23. Radiographs or Models enclosed? | No | Yes | How Many?

				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 any services covered by another plan?				
28. If Prosthesis, is this initial placement?				(If no, reason for replacement) Date of prior placement
29. Is treatment for Orthodontics?				If services already commenced, enter date appliances placed.

DENTIST - CHECK ONE:
❑ Pretreatment Estimate
❑ Statement of Actual Services

Identify Missing Teeth with "X"



30. Remarks for unusual services

31. EXAMINATION AND TREATMENT RECORD - List in order from tooth No. 1 through No. 31. Use Charting System Shown.

Tooth No. or Letter	Surfaces	DESCRIPTION OF SERVICES (Including X-rays, Prophylaxis, Materials used, etc.)	ADA Procedure Number	Date Service Performed Mo. Day Yr.	Fee

TOTAL FEE CHARGED

CERTIFICATION: I hereby certify that the services listed above have been performed on the dates indicated and that the fees submitted are the fees I have charged and intend to collect for those purposes.

SIGNED (DENTIST) _____ DATE _____

Form approved by the Council on Dental Care Programs of the A.D.A. 1975

Pretreatment Estimate of Benefits

A Pretreatment Estimate of Benefits lets you know in advance what your benefits will be. Before signing a course of treatment, have your dentist estimate the charges and submit for a pretreatment estimate. This will eliminate misunderstanding and let both you and your dentist know what the plan will pay. If your dental coverage terminates for any reason during treatment, only the procedures performed before the dental coverage terminated will be eligible for payment. You should review your booklet for full information regarding your coverage.

We recommend a pretreatment estimate if your dental work will cost $200 or more.

Tips to Speed Claims Processing

Part 1 - Employee

Missing or incomplete responses on claim forms cause delays in processing a claim. The items most frequently left out are:

#4 Date of Birth: Helps identify an insured and determine dependent eligibility.

#6 Social Security Number: This is the most important identifier for the plan member.

#8 Student Status: Required on every claim for a dependent age 19 years and older as student status is subject to change since the last claim was processed.

#11 Coordination of Benefits: The "No" box in Question 11 should be checked if no other DENTAL coverage exists. If there is other DENTAL coverage, the additional information requested is necessary for coordination of benefits as required by most group insurance plans. This information is required on every claim as it is subject to change since the last claim was processed.

Signatures: There are two signature lines on the claim form. The left signature line is for the patient to sign which authorizes release of information by the dentist relative to the immediate claim.

The right signature line should be signed by the plan member if you want RSL to pay your dentist. If not, this line should be left blank.

Part 2 - Information Provided by Dentist

Films and Charting: Certain procedures are reviewed by our Dental Consultants. Include films with surgical extractions, crowns, inlays, and bridges. Duplicate films should be labeled left and right. All films should be dated. Periodontal charting and/or films are required for all reported periodontal procedures.

If diagnostic films and charts are unavailable, a narrative should be included on, or attached to, the claim.

Prosthesis-Initial or Replacement: Required for crowns, inlays/onlays, bridges, and partial or complete dentures. If prosthesis is a replacement, the prior placement date is needed.

Pretreatment Estimate Or Actual Services: Appropriate box should be marked to ensure correct handling.

Tooth Number or Letters: Site-specific information is required to process claim. This also includes the listing of the specific quadrant or arch, and tooth number in accordance to the ADA coding.

Electronic Claims Submission

Electronic claims submission is available and a way to reduce the expense associated with claim submission. It is also a way to expedite claims processing.

Access Benefit Information @ www.rsli.com

Dental information including a dental claim form pdf can be at your fingertips by visiting our web site. You will need the free software Adobe Acrobat Reader® to view and print the claim form. If you don't have Adobe Acrobat Reader® installed on your computer, follow the download instructions on our web site.