

MAIL THIS FORM TO:
 SECURITY LIFE INSURANCE COMPANY OF AMERICA
 P.O. BOX 1065
 SCHENECTADY, NY 12301
 TELEPHONE: 1-800-300-9566

PART 1 - TO BE COMPLETED BY SUBSCRIBER **COMPLETE ALL QUESTIONS #1-15**

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|--------------------------------------|--|--|--|--|--|--|---|--|------------|---------------------|---|--|---|--|------|--|
| PATIENT INFORMATION | 1. Patient Name First Middle Last | | | | 2. Relationship to Subscriber Self Spouse Child Other | | | | 3. Sex M F | | 4. Patient Birthdate | | 5. If full time student School City | | | |
| | 6. Subscriber Name First Middle Last | | | | 7. Subscriber or Retiree Social Security/Member ID: | | | | | | Subscriber Birthdate | | | | | |
| | 8. Subscriber or Retiree Address | | | | 9. Spouse Birthdate | | 10. Employer/Union affiliation - Name and address | | | | | | | | | |
| | 11. City, State, Zip | | | | 12. Insured category (check one) <input type="checkbox"/> Subscriber <input type="checkbox"/> Retiree | | | | | | 13. Are other family members employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Family Member Name Social Security No.: | | 14. Name and address of Family Members' Employer in Item 13 | | | |
| | 15. Any other Dental Benefits for Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Coverage through <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent If dependent or spouse, Full Name _____ Give name and address of other coverage above _____ | | | | | | | | | | | | | | | |
| | 16. AUTHORIZATION TO RELEASE INFORMATION - I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, treatment, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable. CERTIFICATION - I hereby certify that the foregoing information is true and correct. | | | | | | | | | | 17. AUTHORIZATION TO PAY BENEFITS TO BELOW NAMED DENTIST - I hereby authorize payment directly to the below named Dentist of the Dental Benefits for services described below. | | | | | |
| Signed (Patient or parent, if minor) | | | | | Date | | | | | Signed (Subscriber) | | | | | Date | |

Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

PART II - TO BE COMPLETED BY ATTENDING DENTIST

| | | | | | | | | | |
|---|--|------------------------|--|--|--|---|-----|--|------------------------------------|
| 18. Dentist's Name | | | | 26. Is treatment result of occupational illness or injury? | | No | Yes | If yes, enter brief description and dates: | |
| 19. Mailing Address | | | | 27. Is treatment result of auto accident? | | | | | |
| City, State, Zip | | | | 28. Other accident? | | | | If yes, name of other plan: | |
| 20. Dentist Soc. Sec. or T.I.N. | | 21. Dentist License # | | 22. Dentist Phone # | | 30. If Prosthesis, is this initial placement? | | (If no, reason for replacement) | 31. Date of prior placement |
| 23. First Visit date current series | | 24. Place of treatment | | 25. Radiographs or models enclosed | | Y | N | # | 32. Is treatment for Orthodontics? |
| If services already commenced, enter Date appliances placed: _____ Mos. treatment remaining: _____ | | | | | | | | | |
| Check One: <input type="checkbox"/> Dentist's Pre-Determination <input type="checkbox"/> Dentist's Statement of Actual Services | | | | | | | | | |

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| DENTIST INFORMATION | <p>Identify Missing Teeth with "X"</p> | | 33. Examination and treatment plan - list in order from tooth No. 1 through tooth No. 32 - use chart shown. | | | | | |
| | Tooth # or Letter | Surface (M, O, D, B, L, La, I) | Description of Service (Including X-rays, prophylaxis, materials used, etc.) | Date service completed | Procedure Number | FEE | | |
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| 34. Remarks for unusual services | | | | | | | | |

I hereby certify that the procedures as indicated by date have been completed and the fees indicated are those actually charged the patient regardless of the existence of insurance coverage.

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| | TOTAL FEE CHARGED | |
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SPECIAL NOTICE

Pre-determination of benefits should be filed when the dentist's estimated charge is \$300 or more. It is to your advantage to know the benefits before you agree to have the work completed.

ATTENTION

This form must be used to report the completion of covered dental services when prior review is not requested.

INSTRUCTIONS TO INSURED

1. Fill in Part I - Identification section (both patient and insured sections). Show relationship and date of birth.
2. Give form to dentist to complete Part II.
3. Mail to the Dental Department:

**SECURITY LIFE INSURANCE COMPANY OF AMERICA
P.O. Box 1065
Schenectady, NY 12301**

4. Any questions concerning your claim should be directed to the Dental Department at the above address or by calling: **1-800-300-9566**.

ELECTRONIC DENTAL CLAIMS PROCESSING IS AVAILABLE THROUGH
EMDEON

OUR EMDEON PAYER ID IS CX092.

IF YOU DO NOT CURRENTLY BILL YOUR PATIENT CLAIMS ELECTRONICALLY TODAY, WE
ENCOURAGE YOU TO CALL EMDEON AT 1-888-255-7293 TO OBTAIN INFORMATION ABOUT
THIS COST SAVINGS PROCESS.

<http://www.emdeon.com/Dentists/dentists.php>

DentalSupport@Emdeon.com