Dental Claim Statement

GE Financial Assurance
Employer Services Group

Group Dental Benefits
GE Group Life Assurance Company
PO Box 1477
Greenfield, MA 01302-1477

Helpful information about filing for benefits is included on the reverse side. For further assistance, call Group Policyholder Service: 1-800-451-2513.

Part I - Employee's Statement - Please Print

Name of Employee (Last, First, Middle Initial)	EE Social Security Number - -	Date of Birth / /	Sex ☐ Male ☐ Female	Group Account Number
Employee's Complete Home Mailing Address (No., Street, City, State, Zip)		Employer's Name		
Is spouse employed? ☐ Yes ☐ No	Spouse's Name	Spouse's Date of Birth / /	Spouse's Social Security Number - -	
Name of Patient (Last, First, Middle Initial)	Date of Birth / /	Relationship to Employee	Does employee have custody? ☐ Yes ☐ No	Patient's Social Security Number - -
Is patient covered by any other dental plan? ☐ Yes ☐ No	If Yes, Give Name of Carrier	Subscriber's Name/ Relationship to Patient	Group Number	Check One ☐ Family ☐ Single
Is dependent (19 yrs. or older) a full-time student? ☐ Yes ☐ No	If Yes, School Name and City		Expected Date of Graduation	

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the provider named below on this claim for the group dental benefits otherwise payable to me, but not to exceed the charges shown. I understand that I am financially responsible for any charges not covered by this authorization.

Signature of Employee	Date

RELEASE AUTHORIZATION: I authorize the following persons and/or institutions that have any records or knowledge of me, my employment, and my health including HIV and/or AIDS related information to give any such information to GE Group Life Assurance Company (hereinafter "GEGLAC") and its legal representatives: Any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, Third Party Administrator, the Medical Information Bureau, or any similar organization, institution or person, any employer, group planholder or certificateholder. If the record contains information relating to HIV test results, AIDS, alcohol or drug abuse or mental health care, enough of this information is also to be released to accomplish the purposes for which the information is requested and to the extent permitted by law. I understand that the information released to GEGLAC will be used in processing my claim for dental benefits. GEGLAC may redisclose such information for that purpose to the employer or union connected with the group dental benefits involved herein, the group planholder or certificateholder, or their representatives, Third Party Administrator, to any reinsurer, to my spouse and to any person or entity performing a business or legal function for the benefit of GEGLAC or the Employer. This information may also be redisclosed as otherwise specifically permitted or required by law. This authorization or photocopies of it will be valid for the term of the coverage of the plan. The information released to GEGLAC will not be given, sold, or transferred to any other person not mentioned above. I understand that I am entitled to a photocopy of this authorization upon request.

Signature of Employee	Date	Signature of Dependent Patient (Parent should sign for minor child)	Date

Part II - Attending Dentist's Statement - Please Print

Name of Dentist (First, Last)	Dentist's Telephone Number	Name of Patient (Last, First, M.I.)	Is dentist related to patient by blood or marriage? ☐ Yes ☐ No Relationship ______
Dentist's Office Location (No., Street, City, State, ZIP Code)		**Orthodontic Treatment** ➤ Date Appliance Inserted	Expected Treatment Duration: ______ Months; Class of Malocclusion ☐ I ☐ II ☐ III
Dentist's Tax I.D.	New location? ☐ Yes ☐ No; More than 1 office? ☐ Yes ☐ No	Is treatment the result of an accident? ☐ Yes ☐ No If Yes: ☐ Occupational ☐ Auto ☐ Other	For crown, bridge or other prosthesis: Is this initial placement? ☐ Yes ☐ No; If not, date of prior placement. Mo. ______ Year ______
Remarks		Prior partial? ☐ Yes ☐ No; If No, Date of Extractions	Teeth Involved in Prior Prosthesis
		Final Prep Date ______ Impression Date ______	Seat Date ______

IDENTIFY MISSING TEETH WITH AN "X" FOR ALL SUBMISSIONS

FACIAL
UPPER 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16; A B C D E F G H I J
LINGUAL
RIGHT PRIMARY LEFT PERMANENT
LOWER 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32; K L M N O P Q R S T
LINGUAL
FACIAL

Examination and Treatment Plan- List in order from tooth No. 1-32 (Use Chart System Shown)

Tooth Number or Letter	Surface	Description of Service (including X-rays, prophylaxis, materials, etc.) Line No.	Date Service Performed MM DD YY	Procedure Number	Fee	For Administrative Use Only

Radiographs or Model Enclosed ☐ Yes ☐ No	Dentist's Signature	Date	☐ X-Rays Returned to Dentist

I hereby certify that the procedures as Indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

PREDETERMINATION OF BENEFITS DOES NOT GUARANTEE PAYMENT - Predetermination of your claim advises you in advance of the amount of benefits payable if described procedures are performed during a period of patient's eligibility. Benefits payable are subject to COB and other policy provisions.

How to File Your Claim

1. Complete Part I - Employee's Statement.
2. Have your Dentist complete Part II - Attending Dentist's Statement.
4. Be sure form is completed. Mail completed form to address shown below.

Mail Completed Claim To:

Group Dental Benefits
GE Group Life Assurance Company
PO Box 1477
Greenfield Massachusetts 01302-1477

State law, in some states, requires the following statement: A person commits a fraudulent insurance act, which is a crime, if he or she knowingly and with intent to defraud any insurance company or other person, either: (1) Files a statement of Claim containing any materially false information; or (2) Conceals for the purpose of misleading, information about any fact that is material to a claim. VIOLATIONS ARE SUBJECT TO CRIMINAL PROSECUTION AND MAY ALSO RESULT IN SUBSTANTIAL CIVIL PENALTIES.

If you have any questions, please contact our Group Policyholder Service number: **1-800-451-2513.**