

KLAIS & COMPANY, INC.

EMPLOYEE BENEFIT CONSULTANTS AND ADMINISTRATORS

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AKRON, OHIO 44313-6977

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BENEFIT REQUEST FORM FOR GROUP DENTAL BENEFITS

TO BE COMPLETED BY EMPLOYEE

1. Employer _____ City _____ State _____ Group # _____
2. Employee Name _____ Date of Birth _____ / _____ / _____
3. Home Address _____
Number _____ Street _____ City _____ State _____ Zip _____
4. Marital Status: Single Married Divorced Widowed Social Security Number _____ - _____ - _____
5. Telephone No. (____) _____
6. Is this claim for a dependent? Yes No If yes, give name _____
Relationship _____ Date of Birth _____ / _____ / _____ Married Yes No Full-time Student Yes No
Name & Address of University _____
7. Are you: Active Employee
 Retired: Date Retired _____
 Cobra Participant
8. Is this request based on an accident? Yes No If yes, give date _____
Where did the accident occur? _____
How did it happen? _____
9. Is this claim the result of a work related illness injury? Yes No
10. Is your spouse employed? Yes No If yes, give name of spouse _____
Name of spouse's Employer _____ Phone No (____) _____
Employer's Address _____
11. Is patient covered for benefits by any other:
- | | YES | NO |
|--|--------------------------|--------------------------|
| A. Group Health Benefits of any kind through an Employer, Union, Welfare Plan or a School? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Coverage of medical care expenses provided through any Federal, State, Provincial or other Governmental Agency? | <input type="checkbox"/> | <input type="checkbox"/> |
- If any of the above are answered yes, please complete the following:
Other Employer _____ Other Insurance Co. or Benefits Plan _____
Address _____ Address _____
Telephone No. (____) _____ Telephone No. (____) _____ Policy No. _____
If Blue Cross show Group and Cert. No. from Blue Cross ID Card _____
Group No. _____ Cert. No. _____
12. Is this patient related to the provider? Yes No If yes, describe the relationship _____
13. I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacist to release any information requested with respect to this request for benefit.

It is unlawful to knowingly provide false, incomplete or misleading facts or information regarding a claim for the purpose of defrauding or attempting to defraud to receive benefits. Penalties may include imprisonment, fines, denial of benefits, and/or civil damages.

Date _____ 20____ Signature of Employee _____

COMPLETE THIS SECTION ONLY IF YOU WISH THE BENEFITS TO GO DIRECTLY TO THE PROVIDER

Authorization to Pay Benefits: I hereby authorize payment directly to: any dentist or provider of service for which I am submitting attached billings and charges.

For the expenses provided under my Group Dental Expense Benefits, I understand I am financially responsible for charges not covered by this authorization.

Signature _____