INTERNATIONAL BENEFITS ADMINISTRATORS L.L.C
100 GARDEN CITY PLAZA, SUITE 110
GARDEN CITY, NY 11530

DENTAL CLAIM FORM

TO BE COMPLETED BY EMPLOYEE

NOTE: If all questions are not answered, there may be a delay in processing this claim, and this form may be returned to you for completion.

EMPLOYER'S NAME MUST BE COMPLETED OR CLAIM WILL NOT BE PROCESSED

NAME OF EMPLOYEE	MARRIED ☐ SINGLE ☐	EMPLOYEE'S SOCIAL SECURITY NUMBER	
EMPLOYEE'S ADDRESS / CITY / STATE		TELEPHONE	DATE OF BIRTH
SPOUSES NAME (IF APPLICABLE)	WAS YOUR SPOUSE EMPLOYED AT THE TIME THIS CLAIM OCCURRED? ☐ YES ☐ NO		
IF YES, NAME OF EMPLOYER, STREET ADDRESS, CITY, STATE, ZIP			
DO YOU OR YOUR DEPENDENTS HAVE ANY OTHER GROUP INSURANCE? IF YES, PLEASE INDICATE NAME OF CARRIER AND ORGANIZATION THROUGH WHOM COVERAGE IS ARRANGED ☐ YES ☐ NO			

PATIENT INFORMATION

NAME OF PATIENT	SEX MALE ☐ FEMALE ☐	PATIENTS SOCIAL SECURITY NUMBER	
STREET ADDRESS / CITY / STATE		TELEPHONE	DATE OF BIRTH
IS THIS CLAIMTHE RESULT OF AN ACCIDENT? IF YES, GIVE DETAILS DATE AND TIME. ☐ YES ☐ NO			
IS THIS CLAIM THE RESULT OF AN AUTOMOBILE ACCIDENT? ☐ YES ☐ NO	IS THIS CLAIM THE RESULT OF AN OCCUPATIONAL ACCIDENT OR ILLNESS? ☐ YES ☐ NO		

I herby certify that the statements herein and attached are to the best of my belief accurate, and I herby authorize my physician, hospital, pharmacy, insurance company, employer or organizations to release any information regarding the medical history, treatment, disability or benefits payable to this claim, to IBA or its representatives. I acknowledge and agree that the plan is subrogated to my rights against any third party to the extent of any payments by the plan. A photostat of this authorization shall be as valid as the original.

Any person knowingly and with intent to defraud any insurance company or other person, files a statement or claim containing any material false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent act and is subject to civil or criminal penalty.

Employee's Signature

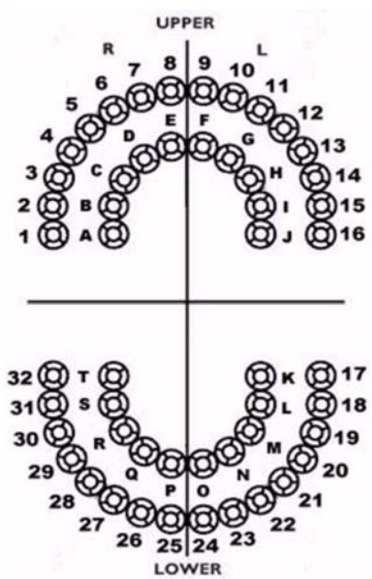
Signature (Patient if 18 or older)

DATE

WHEN COMPLETED MAIL TO: INTERNATIONAL BENEFITS ADMINISTRATORS, 100 GARDEN CITY PLAZA, SUITE 102, GARDEN CITY NY 11530

ATTENDING DENTIST'S STATEMENT OF CLAIM

PATIENT'S NAME				
PATIENTS RELATIONSHIP TO EMPLOYEE	PATIENTS BIRTHDATE	DATE PATIENTS FIRST VISIT (CURRENT SERIES)		
DENTIST NAME	IS PATIENT COVERED BU OTHER PLAN (NAME OTHER PLAN)		YES	NO
DENTIST MAILING ADDRESS	IS ANY TREATMENT FOR ORTHODONTIC PURPOSES			
CIY STATE ZIP CODE	TREATMENT RESULT OF ACCIDENT			
DENTIST (SOC, SEC, or T.I.N) DENTIST LICENSE # PHONE #				
IF PROSTHESIS, IS THIS INITIAL PLACEMENT (IF NO, REASON FOR REPLACEMENT)	DATE OF PRIOR REPLACEMENT	ARE XRAYS ENCLOSED		



EXAMINATIONS AND TREATMENT RECORD-LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO.32

TOOTH	SURFACES	DESCRIPTION OF SERVICE	DATE OF SERVICE	PROCEDURE #	FEE	DO NOT USE
				TOTAL FEE CHARGED		

*ENTER DATE THAT SERVICE WAS ACTUALLY COMPLETED. LEAVE BLANK IF CLAIM SUBMISSION IS FOR ESTIMATED BENEFITS

I HERBEY ACCEPT THE FOREGOING TREATMENT PLAN- AND AUTHORIZE REALEASE OF ANY INFORMATION RELATING TO THIS CLAIM

PATIENTS SIGNATURE (OR EMPLOYEE IF MINOR) DATE

I HERBY CERTIFY THAT THE SERVICES LISTED ABOVE WILL BE OR HAVE BEEN PERFORMED

DENTIST SIGNATURE DATE

I HERBEY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE-NAMED DENTIST OF THE BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED THE CHARGES SHOWN ABOVE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHANGES NOT COVERED BY THE PLAN

PATIENTS SIGNATURE (OR EMPLOYEE IF MINOR) DATE