Dental Claim Statement

Sun Life Financial®

Check one: ☐Dentist's pre-treatment estimate ☐Dentist's statement of actual services

A Pretreatment Estimate is requested (not mandatory) by policy provisions for non-emergency treatment plans, $200.00 or $200.00 (See contracts). Utilization of this feature will forewarn a claimant if a certain item or service has limited or no coverage available. A pretreatment estimate is not a guarantee of payment.

PATIENT COVERAGE INFORMATION

1 Patient name (First / M.I. / Last)	2 Relationship to employee	3 Sex	4 Patient birthdate	5 If full-time student
	☐Self ☐Child ☐Spouse ☐Other_____	M F	MO DAY YR	School / City

6 Employee/subscriber name and mailing address	7 Employee/subscriber Soc. Sec. or I.D. no.	8 Employee/subscriber birthdate	9 Employer (company) name and address	10 Group number
		MO DAY YR	Nyack Union Free School District, 13A Dickinson Avenue, Nyack, NY	K1901173

11 Is patient covered by another dental plan? ☐Yes ☐No If "Yes," complete 12-a. Is patient covered by a medical plan? ☐Yes ☐No	12-a Name and address of carrier(s)	12-b Group no(s).	13 Name and address of other employer(s)

14-a Employee/subscriber name *(if different than patient's)*	14-b Employee/subscriber Soc. Sec. or I.D. no.	14-c Employee/subscriber birthdate	15 Relationship to patient
		MO DAY YR	☐Self ☐Parent ☐Spouse ☐Other_____

NOTE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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 costs of dental treatment.) This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Life Insurance Company of New York to use and disclose protected health information.

▶ SIGNED (PATIENT OR PARENT, IF MINOR) DATE

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named entity.

▶ SIGNED (INSURED PERSON) DATE

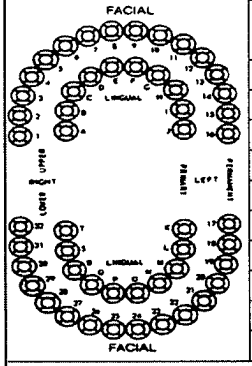
BILLING DENTIST

16 Name of Billing Dentist or Dental Entity	24 Is treatment result of occupational illness or injury?	No	Yes	If "Yes," enter brief description and dates.
17 Address where payment should be remitted	25 Is treatment result of auto accident?			
City, State, Zip	26 Other accident?			

18 Dentist Soc. Sec. or TIN	19 Dentist license no.	20 Dentist phone no.	27 If prosthesis, is this initial placement?			If "No," reason for replacement	28 Date of prior placement

21 First visit date current series	22 Place of treatment Office / Hosp / ECF / Other	23 Radiographs or models enclosed?	No	Yes	How many?	29 Is treatment for orthodontics?			If services already commenced, enter	Date appliances placed	Mos. treatment remaining

Identify missing teeth with "X"



30 Examination and treatment plan—List in order from tooth no. 1 through tooth no. 32—Use charting system shown.

Tooth # or letter	Surface	Description of Service *(including x-rays, prophylaxis, materials used, etc.)*	Date Service Performed Mo Day Year	Procedure Number	Fee

31 Remarks for unusual services

For administrative use only

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.

SIGNED (TREATING DENTIST) LICENSE NUMBER DATE

Total Fee Charged	
Max. allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

Insurance products are underwritten by Union Security Life Insurance Company of New York (Fayetteville, NY) and administered by Sun Life and Health Insurance Company (U.S.) (Windsor, CT).

Sun Life and Health Insurance Company
Administered by: **Sun Life Financial** PO Box 2941 Clinton Iowa 52733