Principal®		minister													Attendir Stateme		ist's
Financial Group	Ins	Principal Life Insurance Company Des Moines, Iowa								Check One:							
Employee Statemer	nt					age 2			iling Instr								
1. Patient name		2	🗆 se	ionship to em elf □ wife □ on □ stepch] husband [3. er □ M □ F		Patient mon pirthdate	th d	ay	year		If full-time stud	dent	City	
6. Employee name First	М	iddle		Last	7.	Employee	e social secu	ırity ı	number S	pouse	e's so	cial se	curity	number 8.	plan and ID Nu	JMBERS (PRIN	ITED ON EMPLOYEE'S I.D. CARD)
														Pla	an		I.D
9. Employee/mailing address	I	ls this a r	iew add	dress?	yes 🗌	no		10	0. Employer (o	ompa	any) n	ame a	nd ac	ldress			
City			S	itate		ZIP)		City						State		ZIP
11. Is employee single married divorced widowed	12. S	Spouse's	name a	and birthdate	month da	ay year		pous yes	se employed?	14	. If "ye	es," gi	ve na	me, address, a	and telephone	number of s	spouse's employer
15. Is patient covered by another p	plan of be	enefits?		f "yes," give n			ntal plan			_					Group	number	
Dental □ yes Medic □ no	al □ y □ r		C	arrying the ot	her coverage	Na	ne me and addr carrier	ess									
I have reviewed the following treat	ment plai	n. I auth	orize re	lease of any i	nformation re	elating to t	this claim.		hereby authori me	ze pa	ymen	t direo	tly to	the below-nar	ned dentist of	the dental b	penefits otherwise payable
Signed (patient or parent if minor)					Date				igned (employ	ee) _							_ Date
Attending Dentist's	Stat	omor	\ #														
16. Dentist name	Siai	emer	<u>ιι</u>					24	Is treatme	nt res	ult	no	ves	If ves. enter	brief descript	tion and date	es
								-	of occupa illness or i	tional			,	, , , , , , , , , , , , , , , , , , , ,			
17. Mailing address								25	5. Is treatme	nt res	ult						
								26	of auto accident?								
City				State		ZIP			 Are any se covered by another pla 	,	\$						
18. Dentist 19. I	Dentist lic anesthes	cense nu sia license	mber/ e numb	er	20. De	entist phor	ne number	28	 If prosthesi this first plate 	s, is	ent			(If no, reaso	on for replace	ment)	29. Date of prior placement
T.I.N. 21. First visit date 22. Place of current series Office 1		eatment 23. Radiographs of sp. ECF Other models enclose				no yes How d? many?			of any type?					If services			·
	nosp.		Julei						orthodontic					already commenced enter			remaining
Identify missing teeth with "X"		mination	and tre	atment plan -				hrou	ugh tooth num				ting s	system shown.			FOR
FACIAL Tooth number Surface (including X-rays, prophylax line num			, ophylaxis,	materials us	sed,	etc.)	Date servic performed mo. day ye		ed	ed	Procedure number	Fe	e	ADMINISTRATIVE USE ONLY			
						1											
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Liberahu as stifts the CO																	
I hereby certify that the proce fees I have charged and inter						npieted	and that t	ne 1	iees submit	ied a	ire th	e aci	ual		@	%	
Signed (Dentist)						I	Date									stimated efits	*

See Page 2 for Statement of Employer Information

USE THIS FORM FOR BOTH EMPLOYEE AND DEPENDENT CLAIMS.

Statement of Employer				
Employee's name		I.D. number	Division	
Date employed	Employee's med plan	Effective date in	n plan	
Is employee's coverage still in for	ce? If no, give te	ermination date.		
	🗆 yes 🔲 no			
Employer			Plan number	
Date	Signature		Title	
			1	
Is employee's coverage still in fore	ce? If no, give te		Plan number	-

Instructions to the Employee

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- 1. Complete questions 1 through 15 on Page 1. Have patient's dentist complete questions 16 through 31.
- 2. If you want benefits paid directly to the dentist, complete the Authorization to Pay on Page 1 following question 15.
- 3. If charges exceed either \$200.00 or \$300.00 (as specified in your Benefit Plan Booklet), a treatment plan must be submitted prior to continuation of treatment.

Instructions to the Dentist

FOR CHARGES <u>LESS THAN</u> AMOUNT SPECIFIED IN YOUR BENEFIT PLAN BOOKLET.	1. 2.	Show the date the work was completed for each service and the corresponding fee. Return this form to Principal Life Insurance Company (The Principal®) (address printed on your ID card.)
FOR CHARGES <u>EXCEEDING</u> AMOUNT SPECIFIED IN YOUR BENEFIT PLAN BOOKLET.		<u>Prior to the continuation of treatment</u> describe procedures necessary to fully complete the treatment plan. State your fees, enclose x-rays (these will be returned to you) and return the form to The Principal (address printed on your ID card.) The Principal will pre-determine the amount payable per procedure and return this form
	2. 3.	After the work is completed, enter the dates that the service was completed and return this form to The Principal (address printed on your ID card.)

Notice!!

THE PRE-DETERMINED BENEFITS APPLY ONLY TO EXPENSES INCURRED WHILE EMPLOYEE'S COVERAGE IS IN FORCE.

PRE-DETERMINATION OF DENTAL SERVICES IS INTENDED TO AVOID ANY MISUNDERSTANDINGS BETWEEN THE DENTIST, EMPLOYEE, AND THE PRINCIPAL. PATIENT WAIVES ADVANCED KNOWLEDGE WHEN NOT OBTAINING A PRE-DETERMINATION AND IS LIABLE IF THE PLAN DOESN'T PAY OR PARTIALLY PAYS FOR TREATMENT.

Please mail completed form to the address printed on your ID card.

For Questions: Please refer to the Toll Free number printed on your ID card.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.