



GROUP DENTAL CLAIM FORM

INSTRUCTIONS: ANSWER ALL QUESTION FULLY, ATTACH ITEMIZED BILLING, AND FORWARD TO BAC AT: PO BOX 107, REYNOLDSBURG, OH 43068-0107 FOR PROCESSING.

A. STATEMENT OF COVERED EMPLOYEE: PLEASE ANSWER QUESTIONS 1-18 FULLY

1.	EMPLOYEE'S NAME (LAST, FIRST, M.):	DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY NUMBER:
2.	HOME ADDRESS:	CITY:	STATE: ZIP CODE:
3.	SEX: <input type="radio"/> MALE <input type="radio"/> FEMALE	MARITAL STATUS: <input type="radio"/> SINGLE <input type="radio"/> MARRIED <input type="radio"/> DIVORCED <input type="radio"/> WIDOWED	IS THIS A NEW ADDRESS?: <input type="radio"/> YES <input type="radio"/> NO
4.	EMPLOYER:	STATUS: <input type="radio"/> ACTIVE <input type="radio"/> RETIRED <input type="radio"/> COBRA	
5.	SPOUSE'S NAME (LAST, FIRST, M.):	SPOUSE'S D.O.B. (MM/DD/YYYY):	SPOUSE'S SOCIAL SECURITY NO.
6.	IS SPOUSE EMPLOYED?: <input type="radio"/> YES <input type="radio"/> NO	SPOUSE'S EMPLOYER:	
7.	ADDRESS OF SPOUSE'S EMPLOYER:	CITY:	STATE: ZIP CODE:
8.	IF AUTO ACCIDENT... PATIENT WAS THE: <input type="radio"/> OWNER <input type="radio"/> DRIVER <input type="radio"/> PASSENGER <input type="radio"/> PEDESTRIAN <input type="radio"/> OTHER:	VEHICLE TYPE: <input type="radio"/> PRIVATE PASSENGER <input type="radio"/> TAXI <input type="radio"/> BUS <input type="radio"/> TRUCK <input type="radio"/> OTHER:	NAME OF THE VEHICLE OWNER: NAME OF THE INSURANCE CO. POLICY NO. STATE IN WHICH ACCIDENT OCCURRED:
9.	FOR ALL ACCIDENTS: DOES THE PATIENT EXPECT TO RECEIVE, OR HAS THE PATIENT RECEIVED, PAYMENT FOR THESE EXPENSES FROM ANOTHER SOURCE AS A RESULT OF A LAWSUIT, WORKMEN'S COMPENSATION OR SETTLEMENT? <input type="radio"/> NO <input type="radio"/> YES, ANSWER NO. 10		
10.	IF YES, PLEASE PROVIDE DETAILS:		
11.	DESCRIBE INJURY OR CONDITION COMPLETELY (IF INJURY INCLUDE HOW, WHEN, & WHERE.):	DATE OF INJURY OR SICKNESS:	
12.	IS INJURY OR SICKNESS DUE TO EMPLOYMENT: <input type="radio"/> YES <input type="radio"/> NO	IF YES, HAVE YOU OR YOUR DEPENDENT FILED FOR WORKMEN'S COMPENSATION:	
13.	ARE YOU OR YOUR DEPENDENT COVERED UNDER ANY OTHER GROUP DENTAL PLAN (INCLUDING BLUE CROSS & BLUE SHIELD), STUDENT OR GOVERNMENT PLAN? (I.E. MEDICARE, MEDICAID, TRICARE): <input type="radio"/> NO <input type="radio"/> YES - PLEASE, COMPLETE NEXT 4 FIELDS		
	NAME OF OTHER INSURANCE COMPANY:	PLAN NUMBER:	
	ADDRESS OF OTHER INSURANCE COMPANY:	EFFECTIVE DATE:	

B. CLAIM FOR DEPENDENT: (COMPLETE SEPARATE FORM FOR EACH DEPENDENT FOR WHICH YOU ARE FILLING A CLAIM)

14.	DEPENDENT'S NAME (LAST, FIRST, M.):	DATE OF BIRTH (MM/DD/YYYY):	SOCIAL SECURITY NUMBER:
15.	DOES DEPENDENT RESIDE WITH EMPLOYEE: <input type="radio"/> YES <input type="radio"/> NO, PROVIDE ADDRESS:	RELATIONSHIP TO EMPLOYEE:	
16.	IS DEPENDENT EMPLOYED: <input type="radio"/> NO <input type="radio"/> F-T <input type="radio"/> P-T	IS CHILD MARRIED: <input type="radio"/> YES <input type="radio"/> NO	IF OVER 19, IS CHILD A FULL-TIME STUDENT: <input type="radio"/> NO <input type="radio"/> YES, WHERE:
			DATE OF CURRENT ENROLLMENT:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A 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.

