Hayward Electric
Dental Reimbursement Plan
Claim Form

THIS SECTION TO BE COMPLETED BY EMPLOYEE:

Name of Employee: _____ Soc. Sec. #_____

Name of Patient: _____ Soc. Sec. #_____

Relationship: Self ___ Spouse ___ Son ___ Daughter ___ Is patient covered under another dental plan? YES ___ NO ___
(OTHER PLAN IS PRIMARY COVERAGE ON ALL CLAIMS.)

If yes, give name of company _____
and attach a payment statement for this claim.

COMPLETE THIS SECTION FOR REIMBURSEMENT REQUEST ONLY:

Amount of Dental Expense for This Reimbursement Claim: $_____

I certify that the charges for which I am requesting reimbursement have been paid in full. I have attached copy of dentist's statement and paid cash receipt, charge card receipt or canceled check to verify this payment.

Signature of Employee:_____ Date:_____

COMPLETE THIS SECTION TO ASSIGN PAYMENT OF BENEFITS ONLY:

Amount of Dental Expense Incurred: $_____

I certify that the charges incurred by me or my dependents are $101.00 or more and are to be paid directly to the Dental Care Provider listed below. I further certify that any and all deductibles, co-payments and excessive charges have already been, or will be, paid by me. I understand that I am responsible for full payment of any treatment(s) that I or my dependents receive.

Signature of Employee _____ Date_____

THIS SECTION TO BE COMPLETED BY DENTAL OFFICE:

CLAIMS OF $101.00 OR MORE MAY BE PAID DIRECTLY TO THE DENTAL OFFICE BY THE HAYWARD ELECTRIC PLAN ADMINISTRATOR IF ASSIGNED BY EMPLOYEE. EMPLOYEE SIGNED CLAIM FORM MUST ACCOMPANY ALL CLAIMS SUBMITTED. SEE REVERSE FOR CLAIM SUBMISSION PROCEDURE.

Name of Dentist _____ License #_____Tax ID#_____

Mailing Address _____ Phone #( )_____

_____ FAX #( )_____

Date of Visit_____Dental Procedure:_____

Procedure is: Complete ___ In Progress___ Dental Charge Incurred for this visit $_____

Payment Made by Other Plan $_____

_____ _____
Signature of Authorized Dental Office Employee Date

CLAIMS MUST BE PROPERLY SUBMITTED WITHIN 90 DAYS OF SERVICE TO BE ELIGIBLE FOR PAYMENT.