



. You are responsible for providing the necessary information in order for us to direct bill your insurance company as well as informing us of any changes in this information.

Details of insurance available online for member

Primary Dental Insurance Info

Subscriber Name: _____

DOB: _____

Relationship to Subscriber: Self / Spouse / Child / other(example- student)

Insurance Company Name: _____

Group / Policy Number: _____

Certificate/ID Number: _____

Maximum Coverage Amount Per Year: \$ _____

When does you insurance year start/roll over: _____

Coverage Basic % _____ Major % _____

Secondary Dental Insurance Info

Subscriber Name: _____

DOB: _____

Relationship to Subscriber: Self / Spouse / Child / other(example- student)

Insurance Company Name: _____

Group / Policy Number: _____

Certificate/ID Number: _____

Maximum Coverage Amount Per Year: \$ _____

When does you insurance year start/roll over: _____

Coverage Basic % _____ Major % _____