

Principal Life Insurance Company Des Moines, Iowa

Attending Dentist's Statement

Check One:

Dentist's Pre-Treatment Estimate

Dentist's Statement of Actual Services

Employee Statement

| 1. | Patient name | | | 2. Relationship to | employee | 3. | Patient | month o | day year | 5. If full-time | e student | City | |
|--|----------------------|--------------------|----------------|----------------------|--|----------------------------------|-----------------------------|------------|------------------|------------------|--------------------|-------------------------|---------------------|
| | | | | | e □ husband □ da pchild □ foster chil | | | | | School | | | |
| 6. | Employee name | First | Middle | Last | 7. Em | oloyee social | security number | Spous | e's social se | curity number | 8. Plan and ID Nu | JMBERS (PRINTED ON EM | PLOYEE'S I.D. CARD) |
| | | | | | | | | | | | Plan | I.D | |
| 9. | Employee/mailing | address | Is this a | a new address? | 🗌 yes 🔲 no | | 10. Emplo | oyer (comp | any) name a | nd address | | | |
| | | | | | | | | | | | | | |
| | City | | | State | | ZIP | City | | | | State | | ZIP |
| | | | | | | | | | | | | | |
| 11 | . Is employee | - | 12. Spouse | 's name and birthda | ate month day | year 13. | Is spouse empl | oyed? 14 | l. If "yes," giv | e name, addr | ess, and telephone | number of spouse's e | mployer |
| | 0 | married widowed | | | | | 🗆 yes 🛛 | no | | | | | |
| 15 | . Is patient covered | by another pla | an of benefits | | e name of person | Dental plan | | | | | Group | number | |
| | Dental □ yes □ no | Medical | □ yes □ no | carrying the | e other coverage. | name Name and a of carrier | address | | | | | | |
| Īh | ave reviewed the fol | lowing treatme | ent plan. I au | thorize release of a | ny information relatir | ng to this clain | n. I hereby a to me | uthorize p | ayment direc | tly to the below | v-named dentist of | the dental benefits oth | erwise payable |
| Signed (patient or parent if minor) Da | | | | Date | | Signed (e | mployee) | | | Date | | | |

Attending Dentist's Statement 16. Dentist name

| 16. Dentist name | | | | | | | | | 24. | | Is treatme of occupa illness or | tional | 1 | no | yes | If yes, enter | brief descript | tion and date | S |
|--|--|------------|----------|------------------------|----------------|----------|-------|---|---|------|---------------------------------------|----------|----------------------------------|--------------|---------------------------------|-----------------|----------------------------|--------------------------------|----------------------|
| 17. Mailing address | | | | | | | | | 25. | | Is treatme | ent res | sult | | | | | | |
| | | | | | | | | | 26. | | of auto ac Other acc | | | | | ł | | | |
| City | | | | State | ZI | Р | | | 20. | A | Are any se | ervice | s | | | | | | |
| | | | | | | | | | | C | covered b another pl | / | | | | | | | |
| | | ense nur | | | 20. Dentist | pho | ne ni | umber | | 6 | another pi | an | | | | | | | |
| T.I.N. | | | | | | | | 28. If prosthesis, is this first placement of any type? | | | | | | | (If no, reason for replacement) | | | 29. Date of prior placement | |
| 21. First visit date 22. Place of Current series Office 1 | | | | 23. Radiographs or | | no | yes | | | | | | | | | 16 | | | d Mars two stress of |
| current series Office Hosp. ECF Other models enclosed? many? | | | | | | 30. | | | treatment for thodontics? If services Date appliances placed Mos. treatment already commenced, enter | | | | | | | | | | |
| Identify missing teeth with "X" | 31. Exar | mination a | and tre | eatment plan - List in | order from | toot | th nu | mber 1 | hroug | gh t | tooth num | ber 3 | 2 - Us | e cha | rting s | ystem shown. | | | FOR |
| FACIAL | Tooth number Surface (including X-rays, prophylaxis, materials us | | | | | | | sed, etc.) | | | pe | erform | e service rformed day year | | Procedure Fee | | ADMINISTRATIVE USE ONLY | | |
| | or letter | | | | | | | | | | | | 1 | ľ. | | | | 1 | |
| | | | | | | | | | | | | | 1 | 1 | | | | ++ | |
| | | | | | | | | | | | | | 1 | i - | | | | · <u>+</u> +· | |
| | | | | | | | | | | | | | 1 | i | | | | ++ | |
| | | | | | | | | | | | | | 1 | 1 | | | | + | |
| RIGHT RIGHT REFERENCE | | | | | | | | | | | | | | | | | | ++ | |
| | | | + | | | | | | | | | + | <u>+</u> | <u> </u> | | | | ·+· | |
| (0) ² (0) ⁷ LINGUAL (0) ¹⁷ (0) (0) ³¹ (0) ⁵ L(0) ¹⁸ (0) | | | <u> </u> | | | | | | | | | <u> </u> | <u>+</u> | <u> </u> | | | | ++ | |
| Ø.Ø. Ø.Ø | | | | | | | | | | | | | † | † | | | | ++ | |
| ක් යුළුවුයු "ස | | | | | | | | | | | | | 1 | † | | | | ++ | |
| | | | | | | | | | | | | | 1 | 1 | | | | | |
| FACIAL | | | | | | | | | | | | | † | 1 | | | | | |
| | | | 1 | | | | | | | | | † | 1 | 1 | | | | | |
| 32. Remarks for unusual services | | | [| | | | | | | | | 1 | 1 | | | | | | |
| | * Th | is is | an i | estimate or | ulv and | 4 0 | doe | es no | nt a | | arante | e r | าลงเ | mer | t | | TAL FEE | | |
| * This is an estimate only , and does no Actual payment will depend on the pla | | | | | | | | | | | | | | CHARC | | | | | |
| | | | | ervices are p | | | | | | | | | | | | Í | | | |
| | | | | | | | | 11115 | COV | ve | laye | 15 5 | ubj | eci | 10 | Covered | Charges | | |
| coordination with other insurance. | | | | | | | | | | | | | Less Ded | uctible | | | | | |
| | Bv/ | | | | | | | | | | Date | | | | | | @ | % | |
| | υу. | | | | | | | | | _ | Dale | | | | | | | | |
| I hereby certify that the proce fees I have charged and inter | | | | | en comple | tec | an | d that | he fe | ee | s submi | ted a | are th | ne ac | ual | | @ | | |
| 5 | | | | • | | | | | | | | | | | | | = | | |
| Signed (Dentist) Date | | | | | | | | | | | | | | | | Total Es Ben | | | |

USE THIS FORM FOR BOTH EMPLOYEE AND DEPENDENT CLAIMS.

Instructions to the Employee

- 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, sign the authorization to pay under the Employee Statement.
- 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. Show the date the work was completed for each service and the corresponding fee. | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| FOR CHARGES <u>EXCEEDING</u> AMOUNT SPECIFIED IN YOUR | Return this form to Principal Life Insurance Company (The Principal [®]) (address printed on your ID card). | | | | | | | | | | |
| BENEFIT PLAN BOOKLET. | Prior to the continuation of treatment 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 to you. | | | | | | | | | | |

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.