

Check One:
 Dentist's Pre-Treatment Estimate
 Dentist's Statement of Actual Services

Employee Statement

See Page 2 for Claim Filing Instructions.

1. Patient name _____ 2. Relationship to employee
 self wife husband daughter
 son stepchild foster child

3. M F 4. Patient month _____ day _____ year _____ 5. If full-time student _____ City _____
 School _____

6. Employee name First _____ Middle _____ Last _____ 7. Employee social security number _____ Spouse's social security number _____ 8. PLAN AND ID NUMBERS (PRINTED ON EMPLOYEE'S I.D. CARD)
 Plan _____ I.D. _____

9. Employee/mailling address _____ Is this a new address? yes no 10. Employer (company) name and address _____
 City _____ State _____ ZIP _____ City _____ State _____ ZIP _____

11. Is employee single married divorced widowed 12. Spouse's name and birthdate _____ month _____ day _____ year _____ 13. Is spouse employed? yes no 14. If "yes," give name, address, and telephone no. of spouse's employer _____

15. Is patient covered by another plan of benefits? Dental yes no Medical yes no If "yes," give name of person carrying the other coverage. _____ Dental plan name _____ Name and address of carrier _____ Group number _____

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I hereby authorize payment directly to the below-named dentist of the dental benefits otherwise payable to me.
 Signed (patient or parent if minor) _____ Date _____ Signed (employee) _____ Date _____

Attending Dentist's Statement

16. Dentist name _____ 24. Is treatment result of occupational illness or injury? no yes If yes, enter brief description and dates _____

17. Mailing address _____ 25. Is treatment result of auto accident? no yes _____
 City _____ State _____ ZIP _____ 26. Other accident? _____

18. Dentist _____ 19. Dentist license no./anesthesia license no. _____ 20. Dentist phone no. _____ 27. Are any services covered by another plan? no yes _____

T.I.N. _____ 28. If prosthesis, is this first placement of any type? no yes (If no, reason for replacement) _____ 29. Date of prior placement _____

21. First visit date current series _____ 22. Place of treatment Office Hosp. ECF Other _____ 23. Radiographs or models enclosed? no yes How many? _____ 30. Is treatment for orthodontics? no yes If services already commenced, enter Date appliances placed _____ Mos. treatment remaining _____

Identify missing teeth with "X"

Tooth # or letter	Surface	Description of service (including X-rays, prophylaxis, materials used, etc.) line no.	Date service performed mo. day year	Procedure number	Fee	FOR ADMINISTRATIVE USE ONLY	
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

32. Remarks for unusual services _____

* This is an **estimate only**, and does not guarantee payment. Actual payment will depend on the plan provisions in effect when the services are performed. This coverage is subject to coordination with other insurance.

By: _____ Date _____

Covered Charges _____
 Less Deductible _____
 _____ @ _____ %
 _____ @ _____ %
 _____ @ _____ %
 Total Estimated Benefits _____ *

I hereby certify that the procedures as indicated by date **have been completed** and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
 Signed (dentist) _____ Date _____

As provider of services and in compliance with "PA Act 165", I verify that all services and materials listed above were necessary and were, in fact, furnished. Signed _____ Date _____

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 LESS THAN
AMOUNT SPECIFIED IN YOUR
BENEFIT PLAN BOOKLET.**

**FOR CHARGES EXCEEDING
AMOUNT SPECIFIED IN YOUR
BENEFIT PLAN BOOKLET.**

1. Show the date the work was completed for each service and the corresponding fee.
2. Return this form to Principal Life Insurance Company (address printed on your ID card).
1. 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 Principal Life (address printed on your ID card).
2. Principal Life 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 Principal Life (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:

PRINCIPAL LIFE INSURANCE COMPANY

**Service Center
Address is shown on the I.D. card**

Notice Requirements

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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: 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.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Virginia: Any person who, with the 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 have violated state law.