

maternity

dental benefit disclosure form

Group Claims Adjusters
 PO Box 82595 / Lincoln, NE 68501-2595
 toll free 800.659.5556 / fax 402.467.7336
 web firstameritasgroup.com



Patient's full name (first, middle initial, last)	Patient birthdate (MM/DD/YY)	Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other
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Employee's full name (first, middle initial, last)	Employee's identification number	Employee's birthdate (MM/DD/YY)
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Employees mailing address (street address or P.O. Box, City, State, ZIP)

Employer (company) name	Group number	Division number	Certificate number
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Pregnancy due date (MMDDYY)	Attending physician's name
	Street address
	City, State, ZIP
	Phone number

I hereby certify that the above information is true and correct and I authorize the release of medical information to First Ameritas Life Insurance Corp. of New York that is necessary to determine and fulfill responsibility for coverage under the provisions of the Maternity Dental Benefit.

To Health Care Providers, Agencies, and Insurance Companies: You are authorized to permit a representative of First Ameritas to obtain or view a copy of the records pertaining to the examination, treatment history, and medical expenses of the named patient or dependent. Such information may be used to the extent deemed necessary by First Ameritas to determine the validity of amount payable for the maternity dental benefit.

X _____ Date _____
 Signature / Employee

X _____ Date _____
 Signature / Patient