Principal Financial Group

Administered by
Principal Life
Insurance Company
Des Moines, Iowa

Attending Dentist's Statement - CA
Check one:
☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services

See Page 2 for Claim Filing Instructions.

Employee Statement

1. Patient name

2. Relationship to employee
☐ self ☐ wife ☐ husband ☐ domestic partner ☐ son ☐ daughter ☐ stepchild ☐ foster child

3. ☐ M ☐ F | 4. Patient birth date | 5. If full-time student School | City

6. Employee name (first, middle, last)

7. Employee social security number | Spouse's or domestic partner's social security number | 8. Plan and ID numbers (printed on employee's ID card) Plan | I.D.

9. Employee/mailing address | Is this a new address? ☐ yes ☐ no

City | State | ZIP | 10. Employer (company name and address)

City | State | ZIP

11. Is employee
☐ single ☐ married ☐ domestic partner ☐ divorced ☐ widowed

12. Spouse's or domestic partner's name and birth date | 13. Is spouse or domestic partner employed? ☐ yes ☐ no

14. If "yes", give name, address and telephone number of spouse's or domestic partner's employer

15. Is patient covered by another plan of benefits? | If "yes", give name of person carrying the other coverage | Dental plan name
Dental ☐ yes ☐ no **Medical** ☐ yes ☐ no

Group number | Name and address of carrier

I have reviewed the following treatment plan. I authorize release of any information relating to this claim.

Signed (patient or parent if minor) _____ Date _____

I herby authorize payment directly to the below-named dentist of the dental benefits otherwise payable to me.

Signed (employee) _____ Date _____

Attending Dentist's Statement

16. Dentist name

17. Mailing address

City | State | ZIP | 18. Dentist T.I.N.

19. Dentist license number/anesthesia license number | 20. Dentist phone number | 21. First visit date current series

22. Place of treatment
office | hosp. | ECF | other

23. Radiographs or models enclosed? ☐ no ☐ yes | How many?

24. Is treatment result of occupational illness or injury? ☐ no ☐ yes | If "yes", enter brief description and dates:

25. Is treatment result of auto accident? ☐ no ☐ yes | If "yes", enter brief description and dates:

26. Other accident? ☐ no ☐ yes | If "yes", enter brief description and dates:

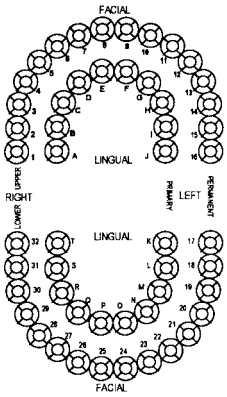
27. Are any services covered by another plan? ☐ no ☐ yes | If "yes", enter brief description:

Attending Dentist's Statement (continued)

28. If prosthesis, is this first placement of any type? ☐ no ☐ yes | If "no", reason for replacement | 29. Date of prior placement

30. Is treatment for orthodontics? ☐ no ☐ yes | If services already commenced, enter date appliances placed | Mos. treatment remaining

Identify missing teeth with "X"



32. Remarks for unusual services

31. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32. - Use charting system shown.

Tooth number or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.) line number	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				
		13				
		14				

* 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.

TOTAL FEE CHARGED

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 _____

Use this form for both employee and dependent claims.

Statement of Employer

Employee's name | I.D. number | Division

Date employed | Employee's med plan | Effective date in plan

Is employee's coverage still in force? ☐ yes ☐ no | If "no", give termination date.

Employer | Plan number

Date | Signature | Title

Instructions to the Employee

1. Complete questions 1 through 15 on Page 1. Have patient's dentist complete questions 16 through 32 on Page 1 & 2.
2. If you want benefits paid directly to the dentist, complete the Authorization to Pay on Page 1 following question 15.
3. If charges exceed $200.00 or $300.00 (or as specified in your benefit plan booklet), a treatment plan must be submitted prior to continuation of treatment.

Print

Instructions to the Dentist

For charges less than 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).

For charges exceeding amount specified in your benefit plan booklet.

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 Principal Life. 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.

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.