MetLife®
Metropolitan Life Insurance Company

# Dental Expense Claim

**To Be Completed by Employee** (You must review the important statements on page 2 and sign where indicated before completing this section of the form.)

| 1. Patient First Name Middle Last | 2. Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other | 3. Sex ☐ Male ☐ Female | 4. Married? ☐ Yes ☐ No | 5. Patient Date of Birth Mo. / Day / Year | 6. For Office Use |
|---|---|---|---|---|---|
| | | | | | |

| 7. If Full Time Student (Age 19 or Over) School City State | 8. EMPLOYEE Social Security / ID Number | 9. If Disabled (Age 19 or Over) ☐ Yes ☐ No | 10. Name of Group Dental Program |
|---|---|---|---|
| | | | ABX Air, Inc. 302073-G |

| 11. Employee First Name Middle Last | 12. Employee Date of Birth | 13. Office Phone (Area Code) |
|---|---|---|
| | | |

| 14. Employee Residence Mailing Address | 15. City, State, Zip |
|---|---|
| | |

| 16. Are other Family Members Employed? ☐ Yes ☐ No Name Social Security / ID Number | 17. Date of Birth | 18. Name and Address of Employer for Item 16 |
|---|---|---|
| | | |

19. Is Patient Covered by Another Dental Plan? ☐ Yes ☐ No (If Yes, complete the following:)
Dental Plan Name Group No. Name and Address of Carrier

| 20. I Authorize Release of any Information Relating to this Claim. | 21. I Certify that the Above Information is Correct. | 22. I Authorize Payment Directly to the Below Named Dentist. |
|---|---|---|
| (Signature of Patient or Signature of Authorized Representative if Minor) Date<br>If Authorized Representative, Relationship to Minor | Employee Signature Date | Employee Signature Date |

**To Be Completed by Dentist**

| 23. Dentist Name | 24. Mailing Address City State Zip |
|---|---|
| | |

| 25. Dentist Social Security Number or T.I.N. | 26. Dentist License Number | 27. Dentist Phone Number |
|---|---|---|
| | | |

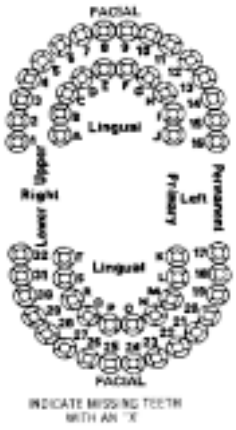
| 28. First Visit Date Current Series | 29. Place of Treatment ☐ Office ☐ Hospital ☐ ECF ☐ Other _____ | 30. Radiographs or Models Enclosed? ☐ Yes ☐ No How Many? _____ |
|---|---|---|
| | | |

| 31. Is Treatment Result of Occupational Illness or Injury? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates) | 32. Is Treatment Result of Auto Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates) |
|---|---|
| 33. Other Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates) | 34. Are any Services Covered by Another Plan? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates) |

| 35. If Prosthesis, is this Initial Placement? ☐ Yes ☐ No (If No, Reason for Replacement) | 36. Date of Prior Replacement? |
|---|---|
| | |

| 37. Is Treatment for Orthodontics? ☐ Yes ☐ No | If Services Already Commenced, Enter | Date Appliance Placed | Months of Treatment Remaining |
|---|---|---|---|
| | | | |

**Dentist's** – ☐ Pre-treatment Estimate ☐ Statement of Actual Services *(Be sure to sign below)**



INDICATE MISSING TEETH WITH AN 'X'

38. Examination and Treatment Plan – List in Order From Tooth #1 through Tooth #32 (Use Charting System Shown)

| Tooth # or Letter | Surface | Description of Services (Including X-Rays, Prophylaxis, Materials Used, Etc.) | Date Service Performed Mo./ Day /Year | ADA Procedure Number | Fee | **For Carrier Use Only** |
|---|---|---|---|---|---|---|
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39. I Hereby Certify That The Services Listed Above ☐ Will Be ☐ Have Been ☐ Performed

*Signature of Dentist _____ Date _____ Total Fee Actually Charged

40. Address where treatment was performed

Street _____

City _____ State _____ Zip _____

If you are covered under a self-insured plan or insured under a policy issued in any state other than those listed below, **or** if you reside in any state other than those listed below, then the following warning may apply to you:

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

If you are insured under a policy issued in one of the following states, **or** if you reside in one of the following states, one of the following state warnings may apply to you:

**New York (only applies to Accident and Health Benefits (AD&D/Disability/Dental):** I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important. I know that if I do this, I may also have to pay a civil penalty of up to $5,000 plus the value of the claim.

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

**Massachusetts:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and may subject such person to criminal and civil penalties.

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

**Oklahoma:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Kansas and Oregon:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

**Virginia:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, files a claim containing a false or deceptive statement may have violated state law.

Employee Signature _____ Date _____

**Please Review Before Submitting Claim**

**Information for Employee**

1. Complete your section of the claim form (items 1 through 21) in full to assure positive identification and prompt payment. Please print or type. **Note:** Item 8 (Employee Social Security Number / ID Number) **must be completed** for the claim to be processed.
2. **Patient Consent.** By signing item 20 the **patient** (or parent or other authorized representative) consents to the use and disclosure of information relating to the services provided by the dentist or health care professional for the purpose of treatment, payment or health care operation, including submission of a claim for dental benefits to a provider or administrator of dental benefit plans. This consent will be valid for as long as the patient is entitled to coverage under a dental plan. You are entitled to a copy of this consent. This consent may be revoked in writing delivered to your dentist or health care professional, but such revocation will not affect any action taken in reliance on this consent prior to revocation. Upon receipt of revocation or refusal to sign a consent, your dentist or health care professional may decline to provide or continue treatment. If this consent is signed by the authorized representative of the patient, the relationship of the authorized representative must be provided in item 20.
3. You must sign the claim form in item 21.
4. You can arrange for MetLife to make payment directly to the dentist by completing item 22. If you wish benefits to be paid directly to yourself, do not complete item 22. In either case, a statement of benefits paid will be sent to you.
5. If total charges for the planned course of treatment are expected to be $300 or more, the form should be completed and submitted to MetLife **prior to the commencement of the course of treatment** for a pre-treatment estimate of benefits. MetLife will notify you of your benefits payable.

   (If you wish, a pre-treatment estimate may be requested for anticipated dental expenses of less than $300.)
6. If total charges for the planned course of treatment will be less than $300, the claim form should be completed when treatment is completed and mailed to the address shown below:

   **Dental Coverage is subject to specific limitations and exclusions. Please refer to your booklet for a description of covered services, schedule of benefits payable, limitations and exclusions.**

**Information for Attending Dentist**

1. Benefits are payable in accordance with four Classes of Services. It is therefore important that a separate fee is indicated for each item of service performed.
2. If total charges for a course of treatment are expected to be $300 or more, check the box noted "Pre-treatment estimate" and complete items 23 through 39. The completed claim form should be sent to the address shown below.
3. If total charges for a course of treatment are expected to be $300 or more, check the box noted "Pre-treatment estimate" and complete items 23 through 39. The completed claim form should be sent to MetLife **prior to the commencement of the course of treatment.** MetLife will review the claim (and any supplementary information required) and notify your patient of the benefits payable.

   A pre-treatment estimate of benefits is not intended to preclude a course of treatment agreed upon by you and your patient. The intent is to avoid any misunderstanding concerning the benefits payable under the dental plan. A pre-treatment estimate is not necessary for oral examinations, cleanings, fluoride applications, dental x-rays, or emergency treatment.
4. If the address where treatment was performed is different than the mailing address in item 24, complete item 40.
5. Generally, we do ***not*** request x-rays where standard filling materials are used. Pre-operative x-rays are requested ***only*** in connection with prosthetics, fixed bridgework, or cast restorations. Occasionally we may request x-rays that relate to other dental services.

   In an effort to reduce your costs and inconvenience, we request your cooperation in submitting x-rays ***only*** in the above mentioned circumstances or when specifically requested. This will also enable us to expedite the processing of a pre-treatment estimate.
6. If authorized by the employee, benefit payments will be made directly to you.

   **Mail Completed form to:**
   **MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282**
   **Employees: 1-800-942-0854**
   **Dentists: 1-877-638-3379**