

ASSIGNMENT OF INSURANCE BENEFITS

CARRIER NAME _____ ADDRESS _____ PHONE # _____

Employee / Subscriber Name First Middle Last			Social Security No.		Date of Birth Mo. Day Year		
Employee / Subscriber Mailing Address				Employer (Company) Name and Address			
City, State, Zip							
Group Number	Location (Local)	Are Other Family Members Employed? Employee Name	Soc. Sec. No.	Name and Address of Employer			
Is Patient Covered By Another Dental Plan?	Dental Plan Name	Union Local	Group No.	Name and Address of Carrier			

	Self	Spouse	Child	Other
Dependents: _____	DOB	____/____/____	_____	_____
_____	DOB	____/____/____	_____	_____
_____	DOB	____/____/____	_____	_____
_____	DOB	____/____/____	_____	_____
_____	DOB	____/____/____	_____	_____

The undersigned, hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____ hereby authorize
Name of Insured
 _____ to pay and hereby
Name of Company

assign directly to Dr. Carl A. Meyers, all dental benefits, if any, otherwise payable to me for his services as described on the attached forms. I understand I am financially responsible for all charges incurred less any dental insurance benefits when received by and paid to Dr. Carl A. Meyers. Authorization is hereby given to release all information necessary to the payment of said benefits. This signature is "IRREVOCABLE", and is valid for two years from this date, unless revoked by me at an earlier date.

_____ Date _____

Authorized Signature of Covered Person/Employee

INSURANCE INFORMATION