DENTAL BENEFIT INFORMATION

DENTAL INSURANCE COVERAGE ❑ YES ❑ NO	DENTAL INSURANCE COMPANY NAME ADDRESS AND PHONE #		
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ❑ SELF ❑ SPOUSE ❑ DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN
GROUP/PROGRAM NAME	EMPLOYER PROVIDING BENEFIT PLAN		
SECONDARY DENTAL INSURANCE COVERAGE ❑ YES ❑ NO	DENTAL INSURANCE COMPANY NAME ADDRESS AND PHONE #		
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ❑ SELF ❑ SPOUSE ❑ DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN
GROUP/PROGRAM NAME	EMPLOYER PROVIDING SECONDARY BENEFIT PLAN		