

# maternity

## dental benefit disclosure form

Group Claim Office  
 PO Box 82520 / Lincoln, NE 68501-2520  
 toll free 800.487.5553 / fax 402.467.7336  
 web ameritasgroup.com



|  |                                  |   |
|--|----------------------------------|---|
| Patient's full name (first, middle initial, last)  | Patient birthdate (MM/DD/YY)     | Relationship to employee<br><input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other |
| Employee's full name (first, middle initial, last) | Employee's identification number | Employee's birthdate (MM/DD/YY)   |

Employees mailing address (street address or P.O. Box, City, State, ZIP)

|                         |              |                 |                    |
|-------------------------|--------------|-----------------|--------------------|
| Employer (company) name | Group number | Division number | Certificate number |
|-------------------------|--------------|-----------------|--------------------|

|                             |                            |
|-----------------------------|----------------------------|
| 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 Ameritas Life Insurance Corp. 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 Ameritas Life Insurance Corp. 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 Ameritas to determine the validity of amount payable for the maternity dental benefit.

X \_\_\_\_\_ Date \_\_\_\_\_  
 Signature / Employee

X \_\_\_\_\_ Date \_\_\_\_\_  
 Signature / Patient