

# DENTAL CLAIM STATEMENT

Helpful information about filing for benefits is included on the reverse side. For further assistance, call Group Policyholder Service: 1-(800)-451-2513.

**Part I - Employee's Statement - Please Print**

Name of Employee (Last, First, M.I.)		EE Social Security Number	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Group Account Number <b>270-0217-00</b>
Employee's Complete Home Mailing Address (No., Street, City, State, Zip)				Employer's Name	
Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse's Name		Spouse's Date of Birth	Spouse's Social Security Number	
Name of Patient (Last, first, middle initial)	Date of Birth	Relationship to Employee	Does employee have custody? <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient's Social Security Number
Is patient covered by any other dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Give Name of Carrier		Subscriber's Name and Relationship to Patient		Group Number
Is dependent (19 yrs. or older) a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, School Name and City			Expected Date of Graduation
<b>AUTHORIZATION TO PAY BENEFITS TO PROVIDER:</b> I hereby authorize payment directly to the provider named below on this claim for the group dental benefits otherwise payable to me, but not to exceed the charges shown. I understand that I am financially responsible for any charges not covered by this authorization.				Signature of Employee	Date

I authorize the release and disclosure of my protected health information and other information as described below.

My **protected health information** is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any health care provider or health care facility to disclose or furnish to **Genworth Life and Health Insurance Company (GLHIC)** including any legal representatives designated by GLHIC the following protected health information: **Dental or Medical records or other information of a medical nature in regard to my physical or mental condition or the physical or mental condition of my dependents.** This authorization extends to and includes HIV-related information, AIDS or AIDS related disorders or information relating to alcohol or drug abuse treatment or services or mental health care to the extent permitted by law.

I further authorize any employer to which this authorization is directed to disclose or furnish my employment, financial and wage information to **GLHIC** and any legal representative that it might designate.

I authorize GLHIC to use or disclose this protected health care information, in connection with payment or health care operations, to any person or entity performing a business or legal function on behalf of GLHIC or as otherwise specifically permitted or required by law. I understand that information disclosed to, or by, GLHIC pursuant to this authorization might be subject to re-disclosure and no longer protected by the HIPAA Privacy Rule.

I understand that: (1) the protected health information being released will be used for the purpose of evaluating a claim for insurance benefits; (2) my refusal to sign this authorization may adversely affect the payment of claims; (3) I have the right to revoke this authorization at any time by writing to GLHIC at the address listed at the top of this form; and (4) I am entitled to a photocopy of this authorization upon request.

This authorization is valid for up to 12 months from the date it was signed. Revocation of this authorization will not affect the rights of any person or entity who acted in reasonable reliance on the authorization before receiving notice of the revocation. A photocopy of this authorization shall be as valid as the original.

Signature of Employee	Date	Signature of Dependent Patient (Parent should sign for minor child)	Date
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**WARNING**

**STATE LAW IN SOME STATES REQUIRES THE FOLLOWING STATEMENT:**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

**THIS NOTICE DOES NOT APPLY IN VIRGINIA.**

**IN CALIFORNIA:** "Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

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

**IN LOUISIANA:** "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

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

**IN NEW YORK:** "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 shall be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each violation."

**IN OREGON:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, which may be subject to prosecution.

**IN PUERTO RICO:** Any person who, knowingly and with the intent to defraud, presents false information in an insurance request for, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or present more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (\$5,000) dollars nor more than ten thousand (\$10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

