BELLSOUTH

CIGNA

Insured and/or Administered by
Connecticut General Life Insurance Company

CIGNA HealthCare

Mail To: Connecticut General Life Insurance Company
P.O. Box 182558
Chattanooga, TN 37422-7558
Toll-Free telephone numbers:

Outside Tenn.	800-251-6401
Tenn.	800-572-7343
Chattanooga	615-499-3100

• and all subsidiaries now or hereafter existing, who are eligible for coverage under these plans."

ACTIVE EMPLOYEE ☐
RETIRED EMPLOYEE ☐

Claim For Dental Expense Benefits

1. PATIENT NAME	2. RELATIONSHIP TO EMPLOYEE soll	3. SEX	4. PATIENT BIRTHDATE	5. IF FULL TIME STUDENT S&OM city

6. EMPLOYEE NAME	7. BIRTHDATE (MO. DA. YR)	8. EMP. SM. SEC. NO.

9. EMPLOYEE MAILING ADDRESS	10. EMPLOYER (COMPANY)
I 1. CITY, STATE, ZIP	12a. IS PATIENT SWiLE ☐ MARRIED :) ☐
	1213. IS PATENT PHYSICCALLY OR MENTALLY HANDr-APPED? 0 YES ☐ NO

13. GROUP NUMBER K-4924)-ASO	14. ARE OTHER FAMILY MEMBERS EMPLOYED? 0 YES ☐ NO	15. NAME AND ADDRESS OF EMPLOYER IN ITEM 14

ili. IS PATIENT COVERED BY ANOTHER DENTAL PLAN	DENTAL PLAN NAME	UNION LOCAL	GROUP NO.	NAME AND ADDRESS OF CARRIER

'if the" expenses are covered by other Insurance and the other carrier Is primary (that Is, pays first), don't file this claim until you have received the payment from the other Insurance. Submit the explanation of benefits from the other carrier with this claim.

17. ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES. I HEARBY CERTIFY TO THE ABOVE STATEMENTS AND AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

Employse SgnaIL- Date

Check I you wish payment sent lo:
☐ You. or
☐ Dentist

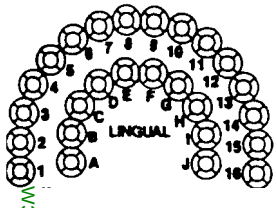
		NO	YES	
18. DENTIST NAME	26AS TREATMENT RESULT OF OGCUPATaLAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTK)N AM DATES
19. MAILING ADDRESS	27.IS TREATMENT RESULT OF AUTO ACCIDENT? 28.07HER ACCIDENT?			
CITY, STATE, ZIP	29.ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
20.DENTIST SOC. SEC. OR T.I.N. / 22. DENTIST PHONE NO.	30.IF PROSTHESIS. IS THIS INITIAL PLACEMENT?			(IF NO. R / DATE OF PMW PLACEMENT
23.FIRST VISIT DATE CURRENT SERIES / 24. PLACE OF TREATMENT OFFICE HOME HOS. OTHER / 25. RADIOGRAPHS YES NO HOW MANY? ENCLOSED? OR MODELS	31AS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED. / DATE APPLIANCES PLACED / MOS. TREATMENT P04A0,10,113

32. DENnsrs
☐ Pro-Treatment
☐ Stateirient of Actual Services

33. Examii,kition and Treatment ftr-Lo in Order Tooth No. I Through Tooth No. 32
Use Charting System Show

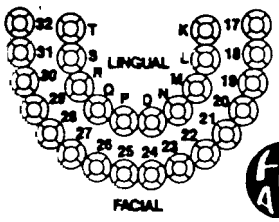
`-Wacate Missing Teeth With an 1C

FACIAL



W3&MI L

LEFT



REMARKS FOR UNUSUAL SERVICES

Tooth f or Letter	Surfaces	DESCRIPTION OF SERVICE (Incluiling X-Rays. Pro0y&- Male,natis Used. Etc.)	Date Service Perlormed W. Da. Yr.	ADA Procedure Number	Fees	For Carrier use Only,

I hereby cw* Mitt the poceckires as indlicated by date have been completed.

TOTAL FEE ACTUALLY CHARGED

34.
Signed (Do") Dale