RESET FORM

maternity Dental Benefit Disclosure Form

Ameritas Life Insurance Corp.

Group Claim Office / P.O. Box 82520 / Lincoln, NE 68501-2520 / Toll Free 877-487-5553 / Fax 402-467-7336 / Web ameritas.com

Patient's full name (first, middle initial, last)	Patient birthdate (MM/DD/YY) / /	Relationship to employee ☐ self ☐ spouse ☐ child ☐ 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 (MM/DD/YY) / /	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 _____ _____

Signature / Employee Date

X _____ _____

Signature / Patient Date