RESET FORM

Maternity Dental Benefit Disclosure Form

Ameritas

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

I hereby certify that I qualify for the Maternity Dental Benefit under this plan.

X _____ _____
Signature / Employee Date

X _____ _____
Signature / Patient Date