INSTRUCTIONS FOR FILING DENTAL CLAIMS

PLEASE DO NOT SUBMIT THIS FORM FOR PRECERTIFICATION.
AFLAC DOES NOT REQUIRE PRECERTIFICATIONS AND WILL NOT COMPLETE THE FORM FOR PRECERTIFICATION.

1. All claims must be submitted on a typed ADA claim form; a copy is on the back of these instructions. Your dentist may prefer to file your claims electronically.

2. Only dental claims may be filed with this claim form. If you need to file a claim under another Aflac policy, please submit the appropriate claim form.

3. Please ask your dentist's office to complete the entire form. Blank fields will cause the form to be returned and the claim processing to be delayed. We must have the following information:

   • The policyholder's dental policy number (Please leave the Group Field blank).
   • The policyholder's complete name as it is printed on the Dental Plan ID card.
   • The patient's full name, sex, date of birth and relationship to the insured.
   • The treatment date, tooth or surface, oral cavity and if initial placement, ADA code and charge for each procedure.
   • The patient's Social Security number. (This will speed up claim processing.)

4. If the patient is a full-time student and over age 19, please indicate this on the form.

5. If you are filing for the initial benefit under the Orthodontic Rider or a cosmetic rider benefit, there is a two-year waiting period before benefits are payable under these riders.

6. Your dentist may submit the claim electronically. Make sure that Aflac's payer number (58066) is included on each claim submitted.

Submit the typed claim form directly to Aflac at:
Aflac Worldwide Headquarters
Attention: Claims Department
1932 Wynnton Road
Columbus, GA 31999-7254
Fax: 1-877-44-AFLAC (1-877-442-3522) Attn: Dental Claims

If you have any questions, please call our toll-free number 1-800-99-AFLAC (1-800-992-3522) or visit our Web site at www.aflac.com.
PATIENT

8. Patient Name (Last, First, Middle) 9. Address 10. City 11. State 12. Date of Birth (MM/DD/YYYY) __/__/_____

17. Relationship to Subscriber / Employee: Self Spouse Child Other ___________________
18. Employer / School Name: _________________________________________
Address: ________________________________________

SUBSCRIBER / EMPLOYEE

19. Subs. SSN # 20. Employer Name 21. Policy # 22. Subscriber/Employee Name (Last, First, Middle)
29. Marital Status Married Single Other M F
30. Sex M F

31. Is patient covered by another plan No (Skip 32-37) Yes Dental or Medical
32. Policy #
33. Other Subscriber’s Name
34. Date of Birth (MM/DD/YYYY) / /_____
35. Sex M F 36. Plan/Program Name
37. Employer / School Name: __________________Address________________
38. Subscriber/Employee Status Employed Part-time Status Full-time Student Part-time Student
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges.

OTHER POLICIES

40. Employer/School Name __________________Address________________
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity 43. Phone Number () 44. Provider ID # 45. Dentist Soc. Sec. or T.I.N.
46. Address 47. Dental License # 48. First visit date of current series:
49. Place of treatment Office Hosp. ECF Other
54. Is treatment for orthodontics? Yes No
55. If prosthetics (crown, bridge, dentures), is this initial placement? Yes No
56. Is treatment result of occupational illness or injury? No Yes
57. Is treatment result of: Auto Accident? Other Accident? Neither

Diagnosis Code Index (optional)

1. _________ 2. _________ 3. _________ 4. _________ 5. __________ 6. __________ 7. __________ 8. __________

Examination and treatment plans. List teeth in order.

Date (MM/DD/YYYY) Tooth Surface Diagnosis Index # Procedure Code Qty Description Fee

Identify all missing teeth with X

Permanent Primary Total Fee

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 A B C D E F G H I J T S R Q P O N M L K

Payment by other plan

Max. allowable

Remarks for unusual services:

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

Signed (Treating Dentist) License # Date (MM/DD/YYYY)

Address where treatment was performed.

63. ___________________ 64. City 65. State 66. Zip Code
AUTHORIZATION TO OBTAIN INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), consumer reporting agency or employer. “Information” means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, or any other non-medical facts that Aflac deems appropriate to evaluate claims for benefits during the time this authorization is valid. I understand that any disclosure of information to Aflac for the purpose of evaluating claims for benefits for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac to evaluate claims for benefits.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization, or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999.

Unless otherwise revoked, I agree that this authorization will expire two years from the date indicated below.

I agree that a copy of this authorization is as valid as the original.

Signature __________________________ Date __________________________ Printed Name __________________________

Individual/Guardian/Personal Representative

Printed Name __________________________

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:
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Signature __________________ Date __________________ Printed Name __________________

Individual/Guardian/Personal Representative __________________

Printed Name __________________

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

RETAIN THIS COPY FOR YOUR RECORDS