



## Coordination of benefits (part 2)

With the coordination of benefits, you can obtain a reimbursement of up to 100% of your expenses.

Is your spouse covered under an insurance plan with his/her employer?

Yes  No

If yes, please provide the following details:

Name of group dental care insurer		Policy no.							
Spouse's type of coverage: <input type="checkbox"/> Family <input type="checkbox"/> Single		Spouse's date of birth		(YYYY/MM/DD)					
Signature of participant		Telephone no. ( )		Date		(YYYY/MM/DD)			

## Removable prosthesis

Is this an initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, indicate the extraction date for the replaced teeth.		Date		(YYYY/MM/DD)			
In the case of a replacement, please indicate:									
A. The date of prior placement:				Date		(YYYY/MM/DD)			
B. The reason for replacement: _____									
_____									

## Fixed bridges

Please forward pre-treatment panoramic or bitewing X-rays of left and right side. If this is an initial placement, please indicate:									
A. The extraction date of the replaced tooth/teeth:				Date		(YYYY/MM/DD)			
B. The date of prior placement, if a removable partial denture is replaced by the bridge:				Date		(YYYY/MM/DD)			
C. Indicate all missing teeth:									
If this is a replacement, please indicate:									
A. The date of prior placement:				Date		(YYYY/MM/DD)			
B. The reason for replacement: _____									
_____									

## Crowns, veneers, onlays

Please forward periapical X-ray of the tooth taken prior to the treatment.					Is this the initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No				
A. The date of prior placement:				Date		(YYYY/MM/DD)			
B. The reason for replacement: _____									
_____									
C. Pertinent details concerning the treatment: _____									
_____									

## Dentist

Signature of dentist				Date		(YYYY/MM/DD)			
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