

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

E. CLAIMS FILING INSTRUCTIONS

INSTRUCTIONS:

Mail the CLAIM FORM promptly.
Follow these instructions to avoid delay.

1. Complete sections A and B in full to assure positive identification and prompt payment.
2. The Subscriber must sign and date the claim.
3. All Claim forms must be submitted to GHI no later than 180 days after the end of the calendar year in which the service was rendered.
4. If you use a GHI Participating Dentist, payment will be made directly to the dentist.
5. Dental coverage is subject to specific limitations and exclusions. Please refer to your insurance booklet and certificate for a description of covered services, limitations and exclusions.
6. This form will have to be returned if it is incomplete or incorrect.

F. ADDITIONAL DENTAL INSURANCE COVERAGE

If your spouse is employed complete this section below.

If patient is eligible for dental benefits under any other dental insurance policy complete this section below.

EMPLOYER (SPOUSE)	NAME OF POLICYHOLDER
EMPLOYER'S ADDRESS	CERTIFICATE OR IDENTIFICATION NO. EFFECTIVE DATE OF COVERAGE
CITY STATE ZIP CODE	NAME OF PLAN/INSURER
EMPLOYER'S AREA CODE TELEPHONE NUMBER	PLAN/INSURER ADDRESS
SPOUSE'S DATE OF BIRTH MONTH DAY YEAR	

G. DEPENDENT STUDENT INFORMATION

This part must be completed only for those having dependent student coverage if the patient is a dependent student age 19 or over.

I CERTIFY THAT MY DEPENDENT _____ MEETS ALL REQUIREMENTS FOR ELIGIBILITY AS A DEPENDENT STUDENT. A. 19 YEARS OF AGE OR OLDER YES <input type="checkbox"/> NO <input type="checkbox"/> B. UNMARRIED YES <input type="checkbox"/> NO <input type="checkbox"/> C. RECEIVES MORE THAN HALF OF SUPPORT FROM THE EMPLOYEE OR RETIRED EMPLOYEE YES <input type="checkbox"/> NO <input type="checkbox"/> D. IS A FULL-TIME STUDENT AT AN ACCREDITED SECONDARY OR PREPARATORY SCHOOL OR COLLEGE YES <input type="checkbox"/> NO <input type="checkbox"/> E. EXPECTED DATE OF GRADUATION _____	NAME OF SCHOOL
	CITY
	DATE STARTED IF GRADUATED, GIVE DATE
	HAS DEPENDENT SERVED IN THE ARMED FORCES? IF YES, GIVE DATES OF SERVICE. YES <input type="checkbox"/> NO <input type="checkbox"/>
	FROM TO DATE
SUBSCRIBER'S SIGNATURE	

H. DISABLED DEPENDENT OVER AGE 19

If dependent over age 19 is disabled and eligibility has not been established, contact your Health Benefits Administrator, personnel department or business office for special form.

