DENTAL CLAIM FORM

RETURN THIS FORM TO: Nicholas County Board of Education

Actual Charges TO BE COMPLETED BY THE EMPLOYEE Employee's Address Number and Street Married Single Social Security Number XXXXX Employee's Address Number and Street City State Zip Code Claim is For Self Spouse Child Dependent's Name Dependent's Date of Sinth If child is 19 years old or older is (s)he tending school on a full-lime basis? Oyes O No Is the person or whom this claim is being made covered by any other group plan? Yes No Name of School Name of Insurance Company Policy Number Address Address TO BE COMPLETED BY THE DENTIST TORIET MALE TO BE COMPLETED BY THE DENTIST TORIET MALE TO BE COMPLETED BY THE DENTIST TORIET MALE TO BE COMPLETED BY THE DENTIST TORIET COMPLETED BY THE DENTIST TORIET MALE TO BE COMPLETED BY THE DENTIST TORIET MALE TORIET MAL	PLEASE INDICATE	LEASE INDICATE												Dental Care Plan								
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