



Have you attached a copy of your dental bill?

#1 About The Claimant

Employee (Claimant's) Name _____
Employee SSN#: _____
Address: _____
Name of Employer: _____ DIV#: _____
Phone Number During Working Hours: _____
Patient Name: _____
Date of Birth _____
Relationship to Employee: _____

#2 About This Treatment

_____ Preventive (exam, cleaning) _____ Major Restorative (crowns, bridges, etc.) _____ Other (describe briefly) _____
_____ Basic Restorative (fillings, etc.) _____ Orthodontic _____

General Dentist / Specialist (Circle)

#3 About this Claim

Name & Address of Dentist/Specialist: _____
Date(s) of Treatment: _____ Total Cost of Treatment: \$ _____
Amount Paid: \$ _____
Is this claim the result of an accident at work? Yes _____ No _____
Is this claim covered by any other insurance coverage? Yes _____ No _____

DIRECT ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to the below-named dentist of the group dental benefits otherwise payable to me.

Name of Dentist: _____

Employee Signature: _____ Date _____

Mail completed claim form and a copy of the bill to:
KCL Benefit Solutions
P O Box 219325
Kansas City, MO 64121-9325
Phone Toll Free (800) 874-5254 ext. 6046
Fax (816) 931-4006