CLAIM FOR DENTAL EXPENSE BENEFITS

Submit x-rays with:

- treatments involving gold restoration, crowns, root canals, or bridgework

  X-RAYS MAY BE REQUESTED FOR OTHER SERVICES

Any person who knowingly and with intent to injure, defraud, or deceive any insurance Company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

MAIL TO:
CLAIMS DEPARTMENT
P.O. BOX 924408
HOUSTON, TX 77292-4408

PART 1

1. Patient Name	2. Relationship to Employee				3. Sex		4. Patient Birthday			5. If full time student	
	Self	Spouse	Child	Other	M	F	MO	Day	Year	School	City

6. Employee			7. Employee Social Security No.			8. Group number if known
First	Middle	Last				

9. Employee Mailing Address	City, State	Zip

10. I have reviewed the following treatment plan. I authorize release of any information relating to this claim. Patient's Signature (Parent if minor).

PART 2

11. Dentist Name
First Middle Last

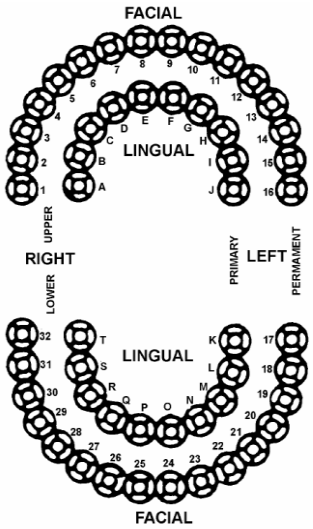
12. Mailing Address	City, State	Zip

TO BE COMPLETED BY DENTIST

13. Dentist Soc. Sec. or ITIN	14. Dentist License No.	15. Dentist Phone No.	16. First Visit Date Current Series	17. Place of Treatment				18. Radiographs or Models Enclosed?	No	Yes	How Many?
				Office	Hosp.	ECF	Other				

19. Dentist - Check One

☐ Pretreatment Estimate
☐ Statement of Actual Services



32. Examination and treatment Plan - List in order from tooth number 1 through tooth number 32
Use chart system shown

For Home Office Only ☐ Schedule ☐ Other

Tooth No. or Ltr.	Surface	Description of Services (including X-rays, Prophylaxis Materials Used, etc.)	Date Service Performed Mo.	Day	Yr.	Procedure Code	Fee			

Dental Unit Use

Employee Eligible Date
Employee Effective Date
Termination Date
Verified By
Date

These benefits will, subject to Policy provisions, be payable if the described procedures are performed while the patient is insured with ManhattanLife Assurance Company of America

Total Fee Actually Charged			
Deductible			
Patient pays			
Insurance will pay			

Part 3

TO BE COMPLETED BY DENTIST

I hereby certify that the services listed above have been performed on the above named patient on the dates indicated

Dentist Signature _____ Date _____

ManhattanLife™

ManhattanLife Insurance and Annuity
PO BOX 924408
Houston, Texas 77292-4408
800-999-2971

HEARING CLAIM FORM

Claimant's Proof of Loss

Patient Name: _____ Date of Birth: _____

Relationship to Insured: _____

Address: _____
Street City State Zip Code

Social Security No: _____ Telephone No: _____

THIS SECTION MUST BE COMPLETED BY THE AUDIOLOGIST/OTOLOGIST

1. Name of Examiner: _____ License No: _____
2. Date of Most Recent Hearing Aid Test: _____
3. Date of Prescription for Hearing Aid: _____
4. In my professional opinion, a hearing aid ☐ is required ☐ is not required
5. Hearing Loss (%) Left Ear_____ % Right Ear_____ %

THIS SECTION MUST BE COMPLETED BY THE HEARING AID DEALER

1. Hearing Aid Center: _____ License No: _____
2. Hearing Aid Type or Mode: _____
3. Cost of Hearing Aid Appliance $ _____

DIAGNOSIS OR NATURE O ILLNESS OR INJUR Y (RELATE DIAGNOSIS TO PROCEDU RE BELO W)

Date(s) of Service MM DD YY	Place of Service	Type of Service	Modifier	Procedures, Services, or Supplies CPT or HCPCS Code	Diagnosis Code	Charges	Or Units	Leave Blank

Federal Tax I.D. Number SSN ☐ EIN ☐	Patient's Account No.	Accept Assignment? ☐ YES ☐ NO	Total Charges $	Amount Paid $	Balance Due $

Signature of Physician or Supplier Including Degrees or Credentials	Name and Address of Facility Where Services Were Rendered (if other than home or office)	Physician's, Supplier's Billing Name, Address, Zip Code and Phone #
Signed _____ Date _____		PIN # _____ GRP # _____

I certify the above is complete and correct and that I am claiming benefits for charges incurred by the above-named patient.

Subscriber Signature _____ Date _____

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

How to File a Claim for Your Dental, Vision and Hearing Policy

Vision

Purchases and Vision Exams at a Retail Store

Most vision care (Exams, eyeglasses, frames, lenses, and contacts) are purchased at retail location, such as Lenscrafters, Costco, Walmart and independent retailers. Most of these locations require you to pay at the cash register, requiring you to file the claim yourself.

Purchases made from an online store

Sometimes vision care (eyeglasses, frames, lenses, and contacts) are purchased from online stores, such as 1800contacts.com, coastal.com or lens.com. If you purchase online your will need to print out the itemized paid receipt provided by the retailer and submit with your completed claim form.

Claim Filing

We accept the HCFA 1500 (Health Care Financial Administration) standardized health insurance claim form or the Vision Claim Form at www.manhattanlife.com

Your policy will consider charges for basic eye exams, refractions, eyeglasses and contact lenses.

In the information section of the form, you or your physician must fill in the following information.

- Insured's full name and address
- Insured's ID Number
- The name and date of birth of the insured receiving the vision services.

If your vision care provider files the claim for you

Many ophthalmologists and optometrists will file the claim on your behalf. Many may ask that you pay your share of the cost at the time of the visit. Show your ManhattanLife Insurance and Annuity Company ID card to your vision care provider.

Hearing

Claim Filing

We accept the HCFA 1500 (Health Care Financial Administration) Standardized health insurance claim form or the Hearing Claim at www.manhattanlife.com

Your policy will considered charges for hearing exams due to hearing loss and the cost of hearing aids.

In the information section of the form, you or your physician must fill in the following information.

- Insured full name and address
- Insured's policy number
- The name and date of birth of the insured receiving the hearing services.

If your hearing care provider files the claim for you

Many audiologists and otologists will file the claim on your behalf. Many may ask that you pay your share of the cost at the time of the visit. Show your ManhattanLife Insurance and Annuity Company ID card to your hearing care provider.

Attachment of Supporting Documentation for Vision and Hearing Claims

You should substantiate your claim expenses by attaching itemized bills and receipts, which contain the following information.

- Insured's full name and address
- Insured's ID number
- Provider's name and address
- Dates that care or treatment was provided
- Physician's and/or Retailer's Tax ID Number
- Dates that hearing aids and/or glasses/contacts were purchased
- ICD diagnosis codes
- CPT/HCPCS procedure codes
- Description of each treatment
- Charge for each service.

Dental

Claim Filing

A dental insurance claim form is submitted to request payment for services rendered or to file for per-authorization of services to be performed. We accept the ADA's (American Dental Association) standardized dental insurance claim form.

In the information section of the form, you or the dentist must fill in the following information.

- Insured's full name and address
- Insured's ID Number
- The name and date of birth of the insured receiving the dental services.

Attachment of Supporting Documentation

You should substantiate your dental insurance claim expenses by attaching itemized bills and receipts, which contain the following information.

- Insured's full name and address
- Insured's ID number
- Provider's name and address
- Dates that dental care or treatment was provided
- Dentist's Tax ID Number
- Dates that services or treatment were received
- Tooth surface(s) and tooth number(s), arch, quadrant
- ADA procedure codes
- Description of each treatment
- Charge for each service

If your Dental Care Provider Files the Claim for You

Many dental offices will file the claim on your behalf. Some may ask that you pay your share of the cost at the time of the visit. Show your ManhattanLife Insurance and Annuity Company ID card to your dental care provider.

ManhattanLife Insurance and Annuity Company
Dental Vision and Hearing Department
P.O. Box 924408
Houston, Texas 77292-4408
Fax: 713-583-2738

www.manhattanlife.com

ManhattanLife