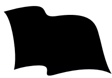

TheStandard®

Standard Insurance Company
Toll Free 888-396-8641 / Fax 402-467-7336 / Web standard.com
Group Claim Office / P.O. Box 82520 / Lincoln, NE 68501

Maternity Dental Benefit
Authorization to Obtain and Release Information

Patient's Full Name (first, middle initial, last)	Patient Birthdate (MM/DD/YY) / /	Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other	
Employee's Full Name (first, middle initial, last)	Employee's Identification number	Employee's Birthdate (MM/DD/YY) / /	
Employees Mailing Address (Street address or P.O. Box, City, State, ZIP)			
Employer (company) Name	Group Number	Division Number	Certificate Number
Pregnancy Due Date (MM/DD/YY) / /	Attending Physician's Name		
	Street Address		
	City, State, ZIP		
	Phone Number		

I hereby certify that the above information is true and correct and I authorize the release of medical information to Standard Insurance Company (The Standard) that is necessary to determine and fulfill responsibility for coverage under the provisions of the Maternity Dental Benefit.

To Health Care Providers, Agencies, and Insurance Companies: You are authorized to permit a representative of The Standard to obtain or view a copy of the records pertaining to the examination, treatment history, and medical expenses of the named patient or dependent. Such information may be used to the extent deemed necessary by The Standard to determine the validity of amount payable for the maternity dental benefit.

X ______________________________ ____________________
Signature / Employee Date

X ______________________________ ____________________
Signature / Patient Date