TheStandard®

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

Pregnancy Dental Benefit

Claimant's Full Name (first, middle initial, last)	Claimant 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

I hereby certify that the above information is true and correct and I authorize Standard Insurance Company (The Standard) to determine coverage under the provisions of the Pregnancy Dental Benefit.

X _____ _____
Signature / Employee Date

X _____ _____
Signature / Claimant Date

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