



The Standard[®]

The Standard Life Insurance Company of New York

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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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 The Standard Life Insurance Company of New York (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