



The Standard®

The Standard Life Insurance Company of New York

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 <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) / /	
Employee's 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 The Standard Life Insurance Company of New York (The Standard) to determine coverage under the provisions of the Pregnancy Dental Benefit.

X _____ Date _____
Signature / Employee _____

x _____ Signature / Claimant _____ Date _____