

Teachers Protective Mutual Life Insurance Company
 116-118 N. Prince Street, P.O. Box 597, Lancaster, PA 17608-0597
 (717) 394-7156

Application for Benefits - Dental, Hearing and Vision Policy

1. Name of Policyholder (Please Print)	Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	Policy #
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2. Street Address	City	State	Zip Code	Telephone #
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3. The expenses included in this claim were for medical services rendered solely to Myself
 An Eligible Dependent

4. If a dependent, answer the following: Male Female Married
 Student Name of School _____
 Year of Graduation _____

Name	Relationship	Date of Birth
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5. Are you or your dependents covered through any other plans which provide dental, hearing, or vision benefits? Yes
 No

<u>Family Member*</u>	<u>Insurance Company Name</u>	<u>Employer Name</u>	<u>Address</u>
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* If spouse, please provide social security # _____ * and date of birth _____

Policy No. Federal, State, or other Gov't Program No.

6. Patient's Authorized Signature: I authorize the release of any medical information necessary to process this claim.
 I authorize payment of medical benefits to physician or supplier for services described herein

_____ _____
 Date Patient Signature

7. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release to Teachers Protective Mutual Life Insurance Company or their duly authorized representative, all information with respect to my self, or any of my dependents, which may have a bearing on the benefits payable under this or any other plan providing benefits or services.. I understand that by the signing of this authorization I waive my right for such information to be privileged. A photostatic of this authorization shall be considered as effective and valid as the original.

_____ _____
 Date Policyholder's Signature