CLAIM FORM

Dental Direct Reimbursement Coverage

EMPLOYEE Name:_____

Street Address/PO Box: _____

City: _____ **State:** _____ **Zip:** _____

Patient's Name _____ **Relationship** _____

Date of Claim(s): _____ **Amount of claim(s):** _____

Dental Provider Name: _____

Dentist must submit the universal American Dental Association form to the address below with this form.

Please send to: **Eagles, Benefit By Design, Inc**
913 Gulf Breeze Prkwy STE 34
Gulf Breeze, FL 32561
email: Dental@CPS125.com
Fax: 772.334.7059

If you have questions, Please call 352.900.1109

PLEASE NOTE: ***All claims for the plan year must be filed within 90 days after the plan year ends.***

Signature: _____ **Date:** _____