



Dental/Vision Claim Form - AOB

Employer _____

Employee _____

Social Security No _____ - _____ - _____ Member ID _____ Birth Date _____

Address _____

City _____ State _____ Zip _____

Phone No _____ E-mail _____

Has your address changed since your last claim? Yes No

Patient Name _____

Relationship to Employee _____ Birth Date _____

If a child over the age of 18, attach proof of full-time student status.

Provider _____

Tax ID No (only required if check paid directly to provider) _____ Phone No. _____

Address _____

City _____ State _____ Zip _____

Was treatment a result of an accident? Yes No

Was treatment for cosmetic care? Yes No

Please attach a copy of the original itemized bill.

Under penalty of law, I agree to the following:

This claim occurred while the patient was covered by this plan. The attached bill is an original and unaltered bill.

Employee Signature _____ Date _____

Assignment of Benefits to the Dentist

I hereby assign my benefits under this plan to the dentist. I understand that my payment under the plan will be mailed to my dentist directly and my dentist may bill me for amounts not covered under the plan.

Employee Signature _____ Date _____

FOR FASTEST SERVICE, PLEASE FAX THIS FORM AND SUPPORTING DOCUMENTATION TO: 1-678-258-8299

Or scan and e-mail to: claims@simple.us

Or mail to: Simple, Claims Department, 1745 North Brown Road, Suite 400, Lawrenceville, GA 30043

Customer Service: 800-270-4158

REMEMBER TO INCLUDE A COPY OF THE ORIGINAL ITEMIZED BILL.

Keep a copy for your records.