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, Benefits By Design (Eagles)**
2336 SE Ocean Blvd., Suite 301
Stuart, FL 34996
Fax 1-772-334-7059

If you have questions, please call 1-800-726-5603.

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

Signature: _________________________________ **Date:** ______________