ACS BENEFIT SERVICES

Coordination of Benefits - Other Insurance Request Form

Dear Subscriber: To Adjudicate your recent Dental Claim correctly we will require the following information. Complete this form and return it to the address at the bottom of the page.

I. Do you or anyone in your family have other dental insurance? Yes _____ No _____

*If you answered **YES** please complete sections I, II and III. If you answered **NO**, please proceed to Section III.*

Subscriber		**Subscriber ID**			
Date of Birth		**Telephone Number**			
Employer		**Insurance Company**			
Plan Number		**Effective Date**		**Term Date**	
Claimants Covered by this Plan					
Name	**Date of Birth**	**Name**	**Date of Birth**		

II. For Dependents of Divorced or Separated Parent.

Is there a court order that states which parent is responsible to provide dental coverage? Yes _____ No _____

If there is no court order, who has custody of the children? _____

Please provide the information below for the responsible party listed above.

Name of Parent who has legal responsibility for the Dental Coverage: _____

Subscriber		**Subscriber ID**			
Date of Birth		**Telephone Number**			
Employer		**Insurance Company**			
Plan Number		**Effective Date**		**Term Date**	
Claimants Covered by this Plan					
Name	**Date of Birth**	**Name**	**Date of Birth**		

III. I hereby certify that the information on this form is accurate and complete.

_____ Signature

_____ Date

_____ Daytime Phone

WHEN COMPLETED PLEASE MAIL THIS FORM TO: ACS Benefit Services, LLC P.O. Box 2000, Winston-Salem, NC 27102-2000