DENTAL CLAIM FORM
CABELL COUNTY BOARD OF EDUCATION
9200 US ROUTE 60 * ONA, WV 25545 * (304) 525-0331 * (304) 525-6005 FAX

EMPLOYEE SECTION

Employee Social Security No. Employee Last Name Employee First Name

Home Phone Number Street Address

City, State, Zip Code Date of Birth

Employed By

Are group health insurance benefits payable from any other source for the expenses submitted?

☐

[redacted]

☐ ☐

[redacted]

Address

[redacted]

☐ Yes No If "Yes," Name Policy No.

Address

If claim is for **Dependent**, answer the following questions: Dependent Name

Dependent's Social Security No. Date of Birth Spouse Child

EMPLOYEE'S ASSIGNMENT

Total

I Hereby Certify That The Services Listed Above Have Been Performed On The Dates Indicated