

# Dental Benefits for Children in Care and Youth Agreements



## A Guide for Dentists, Orthodontists and Dental Specialists

November 2007

This guide is available online at:

[http://www.mcf.gov.bc.ca/foster/pdf/cic\\_dental\\_guide.pdf](http://www.mcf.gov.bc.ca/foster/pdf/cic_dental_guide.pdf)



Ministry of  
Children and Family  
Development

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## INTRODUCTION

This guide provides information for dentists, orthodontists, and dental specialists about dental benefits for children and youth in care and youth receiving support through a Youth Agreement. Please note that the term 'children and youth in care' refers both to children and youth in the care of the Ministry of Children and Family Development (MCFD) and children and youth in the care of Delegated Aboriginal Agencies.

MCFD is responsible for ensuring that children and youth in care and youth receiving support through a Youth Agreement have access to necessary dental care.

MCFD, Medical Benefits Program, provides funding for dental and orthodontic treatment through a contract with Pacific Blue Cross (PBC). Dentists, orthodontists and dental specialists submit claims directly to PBC, who then adjudicates and makes payment on claims dependent on the eligibility outlined within this guide. **Please see pages 4-6: Dental Benefits and/or pages 7-10: Orthodontic Benefits.**

Children and youth who are status Aboriginal peoples may have some of their dental and orthodontic benefits covered through Health Canada, dependent on the eligibility outlined within this guide. **Please see page 4 – Children and Youth Eligible for Dental Benefits and/or page 7 – Children and Youth Eligible for Orthodontic Benefits.**

## DENTAL BENEFITS

### Section 1: Description of Dental Benefits

MCFD, Medical Benefits Program, provides funding for dental treatment for children and youth in care and youth in Youth Agreements, through a contract with Pacific Blue Cross (PBC).

Dental benefits are included in the PBC fee schedule for Plan A and B services. The following services are funded:

- diagnostic
- preventative
- restorative
- endodontic
- periodontic
- prosthodontic
- anaesthesia
- oral surgical services

### Section 2: Children and Youth Eligible for Dental Benefits

Children and youth eligible for MCFD dental benefit coverage are within groups D077030, D077031, D077033, and D077034. The differences between these groups are as follows:

1. Groups D077030 and D077031: All children and youth in care and youth in Youth Agreements, who are not status Aboriginal peoples.

Dental benefits coverage is provided through MCFD/Pacific Blue Cross to an annual limit of \$700.

2. Groups D077033 and D077034: All status Aboriginal children and youth in care and youth in Youth Agreements (**except Nisga'a children and youth – please see page 5, section 3**).

Dental benefits coverage is provided through MCFD/Pacific Blue Cross to an annual limit of \$100. Additional annual coverage of \$600 is provided through Health Canada's Federal Non-Insured Health Benefits Program. All dental claims in excess of the MCFD/Pacific Blue Cross \$100 annual limit should be submitted to Health Canada using the child or youth's Aboriginal status number. **Please see page 11 – Contact Information.**

### Section 3: Dental Benefits for Nisga'a Children and Youth in Care and Youth Agreements

Status Nisga'a children and youth in care and youth in Youth Agreements receive dental coverage through the Nisga'a Non-Insured Health Benefits Program, coordinated by the Nisga'a Lisims Government.

For more information, please contact the Nisga'a Non-Insured Health Benefits Program at **1-866-633-0888** or visit <http://www.nisgaalisims.ca/>

### Section 4: Dental Funding Procedure

Dentists are responsible for:

- confirming the child or youth's dental coverage with Pacific Blue Cross (PBC) at **1-888-419-2236**;
- confirming with PBC that sufficient funds are available within the child or youth's annual dental funding limit, and;
- submitting claims directly to PBC using the child or youth's identification and group numbers and/or Health Canada using the child or youth's Aboriginal status number (if applicable – **please see page 4, Section 2**).

### Section 5: Submitting Dental Claims

Dental claims are to be submitted directly to Pacific Blue Cross (PBC) by mail or via CDAnet (and/or to Health Canada, if applicable – **please see page 4, Section 2**).

Electronic copies of the PBC Dental Claim form are available at <http://www.pac.bluecross.ca/pdf-bin/200/20-70-201ppat.pdf>

CDAnet is a network of Canadian dental offices and insurance companies that allows dental claims to be sent from the dental office to the patient's insurance carrier online. The subscribing dentist must be a member of the Canadian Dental Association or the applicable provincial association.

For more information on CDAnet, please visit [http://www.cda-adc.ca/en/dental\\_profession/practising/cdanet/faqs.asp](http://www.cda-adc.ca/en/dental_profession/practising/cdanet/faqs.asp)

## Section 6: Exceptions to Funding Policy

Type of Exception	Group Number(s)	Application Process
<b>Over-Limit Funding Policy:</b> Request to provide treatment in excess of the annual \$700 limit and/or the annual \$190* anaesthetic limit	D077030 D077031	Prior to providing over-limit services, dental practitioners are asked to submit a written request with a treatment plan (on a standard dental claim form), x-rays and justification to the address below.
<b>Over-Limit Funding Policy:</b> Request to provide treatment in excess of the annual \$100 limit	D077033 D077034	Prior to providing services, dental practitioners are asked to submit an application to Health Canada, Non-Insured Health Benefits Program for all treatment in excess of the \$100 MCFD funding limit. <b>Please see page 4, Section 2 or page 11 - Contact Information.</b>
<b>Emergency Treatment Funding Policy:</b> Request for payment of over-limit treatment which was delivered on an emergency basis and where prior written approval could not be obtained	D077030 D077031	Over-limit services performed under emergency circumstances may be eligible for payment without prior written approval. Dental practitioners are asked to use their professional judgement and consider performing the basic dental treatment required to alleviate the patient's emergent pain and discomfort. After delivery of emergency treatment, please submit the treatment plan, explanation of the circumstances and a request for emergency post-approval authorization to the address below.
<b>Adjustment to Approved Over-Limit Funding:</b> Request for adjustment to a written approval for over-limit funding.	D077030 D077031	Dental practitioners are asked to submit revised treatment plans (on a standard dental claim form) to the address below. The dental practitioner must identify the treatment that was performed and provide a description of the circumstances which necessitated the change. <b>Please see page 11 - Contact Information.</b>  Please request an adjustment before submitting the claim to Pacific Blue Cross (PBC), as PBC will not make payments on any portion of the treatment plan that differs from the plan that was originally approved for over-limit funding.
<b>Exceptional Cases Funding Policy:</b> Request to provide treatment not covered under the standard dental plan	D077030 D077031 D077033 D077034	There is a process in place to review extraordinary funding requests. If a child or youth in care requires dental treatment that is not covered under the standard dental plan, the dentist should send a written request that includes a treatment plan, x-rays and justification to the address below.

\*Based on the Pacific Blue Cross fee schedule

## Section 7: Exceptions to Funding Policy – The Appeal Process

Where a request for exceptional funding is denied, an appeal may be submitted to the Manager, Medical Benefits, at the address below. The appeal request should be supported by additional information or records.

## ORTHODONTIC BENEFITS

### Section 1: Description of Orthodontic Benefits

MCFD, Medical Benefits Program, provides funding for orthodontic treatment for some children and youth in care, through a contract with Pacific Blue Cross (PBC). Eligible children and youth are those in the permanent care/continuing custody of MCFD.

Orthodontic benefits are included in the PBC fee schedule for Plan C services. Funding may be provided for early, limited or full orthodontic treatment.

### Section 2: Orthodontic Funding Criteria

Orthodontic treatment is available to children and youth in permanent care/continuing custody (group D077031 or group D077034 – **please see page 7, Section 3**) with an impairment that is functionally limiting and two or more of the following conditions:

- impinging overbite
- cross-bite causing functional limitation
- skeletal dysplasia which will require surgery
- excessive overjet with lip incompetence
- severe crowding with functional implications
- severe temporomandibular syndrome
- the orthodontic treatment is significant to the child/youth's emotional and psychological development (to be discussed with the child/youth, the foster parent, and the child/youth's MCFD guardianship worker, as appropriate).

Requests for orthodontic treatment will also be considered where a child or youth has a medical condition that is not included in the above criteria, and the treatment is required in order to address a functional impairment.

Please note that MCFD funds basic orthodontic services for eligible children and youth. Ceramic and gold braces will not be considered for funding.

### Section 3: Children and Youth Eligible for Orthodontic Benefits

Children and youth eligible for MCFD orthodontic benefit coverage are within groups D077031 and D077034. The differences between these groups are as follows:

1. Group D077031: All children and youth in permanent care/continuing custody, who are not status Aboriginal peoples.

Orthodontic benefits coverage is provided through MCFD/Pacific Blue Cross to a lifetime maximum of \$5000.

There is a process in place to review extraordinary or over-limit orthodontic funding requests. If a child or youth in care requires orthodontic treatment that exceeds the funding limit, the orthodontist should send a written request that includes a treatment plan, x-rays and justification to the address below.

2. Group D077034: Status Aboriginal children and youth in permanent care/continuing custody.

Orthodontic benefits coverage is provided through MCFD/Pacific Blue Cross to a lifetime maximum of \$500. Additional coverage of \$4500 lifetime maximum is provided through Health Canada's Federal Non-Insured Health Benefits Program. All orthodontic claims in excess of the MCFD/Pacific Blue Cross \$500 lifetime maximum should be submitted to Health Canada using the child or youth's Aboriginal status number. **Please see page 11 - Contact Information.**

#### Section 4: Orthodontic Benefits for Nisga'a Children and Youth in Care and Youth Agreements

Nisga'a children and youth in care and youth in Youth Agreements receive orthodontic coverage through the Nisga'a Non-Insured Health Benefits Program, coordinated by the Nisga'a Lisims Government.

For more information, please contact the Nisga'a Non-Insured Health Benefits Program at **1-866-633-0888**.

#### Section 5: Orthodontic Funding Application Procedure

Orthodontists are responsible for:

- confirming the child or youth's eligibility for initial exam and diagnostic records with Pacific Blue Cross (PBC);
- submitting the application for orthodontic funding to the Medical Benefits Program, and;
- submitting claims for approved treatment to PBC and/or Health Canada (if applicable – **please see page 7, Section 3**).

##### *Confirmation of Eligibility for Initial Exam and Diagnostic Records*

The orthodontist must confirm the child's eligibility for the initial exam and diagnostic records by contacting Pacific Blue Cross (PBC) at **1-888-419-2236**.

The orthodontist should provide the child's identification number and confirm that coverage is open in one of the two groups eligible to apply for orthodontic funding (groups D077031 and D077034 – **please see page 7, Section 3**).

When eligibility has been confirmed, the orthodontist may proceed with the initial exam and records. The claim for the initial exam and records is submitted to PBC on a claim form with the child's group and identification numbers. PBC will make payment directly to the orthodontist.

### *Making the Orthodontic Funding Application*

The orthodontic funding application must be submitted by a certified specialist in orthodontics. Exceptions will be considered if the patient lives in a remote location and does not have access to a specialist.

The application must include the following:

- a completed "Certified Specialist in Orthodontics, Standard Information Form," available online to members of the Canadian Association of Orthodontists;
- a description of the recommended treatment;
- an explanation of how the treatment meets the orthodontic funding criteria;
- radiographs, photographs and cephalometric images (if available), and;
- the total treatment cost, initial fee and monthly/quarterly fees.

Please note that models are no longer required to be submitted with the orthodontic funding application.

Please do not roll or bend records. Improperly packaged records cannot be stored or processed and will be returned with the application.

The orthodontic funding application should be mailed to the address below.

## **Section 6: Orthodontic Funding Application – The Review and Notification Process**

The request for orthodontic funding is reviewed by the Program's consulting orthodontist to determine if it meets the funding criteria. A written decision will be provided within 8 weeks.

Where a request for orthodontic funding is denied, appeals may be submitted to the Manager, Medical Benefits, at the address below. The orthodontist should identify what evidence may have been overlooked in the initial review and resubmit the records, documentation, and any new information to support the appeal.

## **Section 7: Orthodontic Payment Process – Approved Treatment**

Please submit all claims for approved orthodontic treatment to Pacific Blue Cross using the child or youth's dental group and identification numbers (found on his/her dental card).

The initial claim may be up to 50% of the total treatment cost. Claims may be submitted monthly or quarterly, in accordance with the payment plan identified in the orthodontic funding application.

## Section 8: Orthodontic Payment Process – Youth Turning 19

Once a treatment plan is approved, MCFD will assume financial responsibility for the total funding amount approved, even after the youth reaches the age of 19. When a youth reaches 19, the orthodontist must submit the claims to the address below. The invoice should clearly indicate the youth's name and identification number, and specify that it is a ***“request for payment of approved orthodontic treatment for a youth who has reached 19 years of age.”***

## CONTACT INFORMATION

### **Ministry of Children and Family Development**

#### **Dental Benefits**

Mailing Address:

PO Box 9763 Stn Prov Govt  
Victoria, BC V8W 9S5

Physical Address:

2<sup>nd</sup> Floor – 940 Blanshard Street  
Victoria, BC V8W 3E6

Toll Free Phone: 1-877-210-3332

Local Phone: (250) 356-6717

Facsimile: (250) 356-2159

E-Mail: [MCF.MedicalBenefitsProgram@gov.bc.ca](mailto:MCF.MedicalBenefitsProgram@gov.bc.ca)

### **Pacific Blue Cross Dental Department**

Mailing Address:

PO Box 7000  
Vancouver, BC V6B-4E1

Toll Free Phone (for Dental Providers): 1-888-419-2236

Local Phone (Lower Mainland): (604) 419-2600

Web: [www.pac.bluecross.ca/](http://www.pac.bluecross.ca/)

### **Health Canada**

First Nations and Inuit Health Branch (FNIHB)

Pacific Region

Mailing Address:

Suite 540 – 757 West Hastings Street  
Vancouver, BC V6C 3E6

Toll Free Phone: 1-800-317-7878

Local Phone (Lower Mainland): (604) 666-3331

Web: [www.hc-sc.gc.ca/fnih-spni/nihb-ssna/index\\_e.html](http://www.hc-sc.gc.ca/fnih-spni/nihb-ssna/index_e.html)

### **Nisga'a Lisims Government**

Nisga'a Non-Insured Health Benefits

Mailing Address:

Box 231  
New Aiyansh, BC V0J 1A0

Toll Free Phone: 1-866-633-0888

Local Phone: (250) 633-3000

Web: <http://www.nisgaalisims.ca/>

## QUESTIONS AND ANSWERS FOR DENTISTS AND ORTHODONTISTS

**Q:** *I have a child or youth in my office without a dental card. How do I obtain his/her Pacific Blue Cross numbers?*

**A:** Please contact the Medical Benefits Program at the toll-free telephone number below, and request the child or youth's Pacific Blue Cross numbers.

**Q:** *A child or youth in my office needs substantial restorative dental work, which cannot be performed in a regular office setting. Can over-limit funding for the restorations and general anaesthetic be obtained?*

**A:** The Medical Benefits Program will consider requests for funding over the \$700 limit for dental (Plan A/B) services and for funding over the anaesthetic funding limit of \$190.

General anaesthetic administered in hospital is covered by the Medical Services Plan. However, where a booking for general anaesthetic cannot be made in hospital, the Medical Benefits Program will consider requests for over-limit funding for anaesthetic to be administered in a private facility.

Over-limit funding requests must be submitted to the attention of the Dental Benefits Officer at the address below, and must include a treatment plan and x-rays. A written decision will be provided within 6 weeks (for more information, please see page 6).

**Q:** *Does this guide apply equally to youth in a Youth Agreement or Independent Living and youth who are in care?*

**A:** Yes, all aspects of this guide apply to youth in a Youth Agreement or Independent Living. These youth carry their own Pacific Blue Cross dental card and provide their own consent to the dentist, orthodontist or dental specialist to perform the treatment under the authority of the *Infant's Act, s. 17*.

## FORMS

The following forms are attached:

- Certified Specialist in Orthodontics, Standard Information Form – approved by the Canadian Association of Orthodontics. Commonly referred to as the **Standard Orthodontic Information Form.**
- The Canadian Dental Association and the Canadian Life and Health Insurance Association claim form. Commonly referred to as the **Standard Dental Claim Form.**

CERTIFIED SPECIALIST IN ORTHODONTICS

STANDARD INFORMATION FORM



Approved By  
The Canadian Association of Orthodontists

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/Prov: \_\_\_\_\_  
 Postal Code: \_\_\_\_\_  
 Telephone: \_\_\_\_\_

PATIENT IDENTIFICATION

This section to be completed by Patient/Parent/Guardian

Insurance Carrier \_\_\_\_\_

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_

Employer: \_\_\_\_\_  
 Address: \_\_\_\_\_

Group Policy	Certificate #	Soc. Ins. No.
Patient's Birthday		Relationship to Subscriber

**FOR PATIENT USE ONLY**

Name of Patient: \_\_\_\_\_

- Full Treatment Case       Limited Treatment Case       Early Treatment Case

Brief Description of Condition: \_\_\_\_\_

Financial Arrangements:

Preparatory Procedures

Initial Examination \_\_\_\_\_ Date: \_\_\_\_\_

Diagnostic Phase \_\_\_\_\_ Date: \_\_\_\_\_

Starting Date of Active Treatment: \_\_\_\_\_

Treatment Procedures:

Initial Payment \_\_\_\_\_

Monthly Fee  ,or Quarterly Fee

Other Payment Plan \_\_\_\_\_

Retention/Observation Fee \_\_\_\_\_

Estimated Total Fee (If Applicable) \_\_\_\_\_

Additional Explanatory Comments:

\_\_\_\_\_

Date: \_\_\_\_\_

This information is valid  
for 6 months from the above date.

\_\_\_\_\_  
SIGNATURE OF CERTIFIED ORTHODONTIST



**STANDARD DENTAL  
CLAIM FORM**

<b>PART 1 DENTIST</b>		UNIQUE NO.	SPEC.	PATIENTS OFFICE ACCOUNT NO.	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT TO HIM/HER		
P A T I E N T	D E N T I S T	PHONE NO.			SIGNATURE OF SUBSCRIBER		
FOR DENTIST USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATIONS.				I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT. I ACKNOWLEDGE THAT THE TOTAL FEE OF \$ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY / PLAN ADMINISTRATOR. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST.			
				SIGNATURE OF PATIENT (PARENT/GUARDIAN)			
				OFFICE VERIFICATION			
DATE OF SERVICE DAY MO. YR.	PRO- CEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES	
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.						<b>TOTAL FEE SUBMITTED</b>	
<b>INSTRUCTIONS FOR CLAIM SUBMISSION</b>							
BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT, DEPENDING ON WHO IS THE CARRIER FOR YOUR PLAN. YOU CAN OBTAIN DETAILS FROM EITHER YOUR PLAN BOOKLET, YOUR CERTIFICATE OR FROM YOUR EMPLOYER. IF YOU PLAN REQUIRES SUBMISSION DIRECTLY TO THE CARRIER, PLEASE SEND THIS FORM WITH ONLY PARTS 1, 2 AND 3 COMPLETED TO THE CARRIER'S APPROPRIATE CLAIMS OFFICE. IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OFFICE/PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER.							
<b>PART 2 - EMPLOYEE/PLAN MEMBER/SUBSCRIBER</b>							
1. GROUP POLICY/PLAN NO. _____ DIVISION/SECTION NO. _____			2. YOUR NAME (PLEASE PRINT) _____				
EMPLOYER _____			YOUR CERT. NO. OR S.I.N. OR I.D. NO. _____				
NAME OF INSURING AGENCY OR PLAN _____			YOUR DATE OF BIRTH _____ DAY MONTH YEAR				
<b>PART 3 - PATIENT INFORMATION</b>							
1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER/SUBSCRIBER _____			3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS SEPERATELY. <input type="checkbox"/> NO <input type="checkbox"/> YES				
DATE OF BIRTH _____ DAY MONTH YEAR IF CHILD INDICATE: <input type="checkbox"/> STUDENT <input type="checkbox"/> HANDICAPPED			4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT. <input type="checkbox"/> NO <input type="checkbox"/> YES				
IF STUDENT, INDICATE SCHOOL _____			5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? <input type="checkbox"/> NO <input type="checkbox"/> YES				
PATIENT I.D. NO. _____			6. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER / PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.				
2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN, W.C.B. OR GOV'T PLAN? <input type="checkbox"/> NO <input type="checkbox"/> YES			DATE _____ DAY MONTH YEAR				
POLICY NO. _____ SPOUSE DATE OF BIRTH _____			SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER _____				
NAME OF OTHER INSURING AGENCY OR PLAN _____							
<b>PART 4 - POLICY HOLDER/EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE. SEE ABOVE*)</b>							
1. DATE COVERAGE COMMENCED		DAY MONTH YEAR		4. CONTRACT HOLDER		DATE	
2. DATE DEPENDENT COVERED		DAY MONTH YEAR				AUTHORIZED SIGNATURE	
3. DATE TERMINATED		DAY MONTH YEAR				(POSITION OR TITLE)	

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