ORTHODONTIA INFORMATION

Assurant Flexible Spending Department
Fax number: (651) 361-4036
Phone number: (866) 866-4488 ext 4600

ASSURANT®

PART I - TO BE COMPLETED BY EMPLOYEE

Employee Name _____

Employee SSN (last 4 digits) _____

Employee ID Number (7 digits) _____

PART II - TO BE COMPLETED BY ORTHODONTIA / SERVICE PROVIDER

Patient Name _____

Treatment Start Date (mm/dd/yyyy) _____/_____/_____

Total Charge $_____.____

Expected Insurance $_____.____

Initial Payment (up to 25% of Total Charge less Expected Insurance) $_____.____

Total Remaining to be Reimbursed $_____.____

Estimated Length of Treatment (in months) _____

Provider Name _____

Signature of Service Provider _____

Date ____/____/_____

Phone Number _____-_____-_____

Part III - TO BE COMPLETED BY THE FLEXIBLE SPENDING DEPARTMENT

	Year	Months	$$.$$	Total
*				
*				
*				
*				
*				
			Total Reimbursement Eligible $_____.___	

**** Must submit a new claim form each year to be reimbursed***
Once completed we will send you a copy, please keep for your reference