



P.O. Box 67220 Lincoln, NE 68506

Phone: 402-423-4454 Fax: 402-423-4549

Dental Plan Claims Statement

I certify by my signature below that the attached claim/claims in the amount of \$	
are for reimbursement under my employer plan.	
Ford and Control	F. d. com
Employee Signature	Employee SSN
Employer Name	Date