



Benefit Questionnaire

Plan Member Name: _____

Benefit Company: _____ Phone #: _____

Group/Policy #: _____ ID/Certificate #: _____

Please ask your Benefit Company the following questions:

1. What is my maximum dollar amount? _____

2. How much have I used in the current period? _____

3. Is it a calendar year (Jan – Dec) or by anniversary? If so, what is the anniversary date?

4. What is my percentage?
 - a. Basic: _____
 - b. Major: _____

5. How many of units of scaling can I have per year? _____

6. What is my frequency for cleaning?: Polish and fluoride(eg: 6 month, 9 months or 12 months)

7. What is my frequency for recall exams? (eg: 6 month, 9 months or 12 months)

8. Can I request additional scaling units with a pre-determination from the dentist? _____