

# Assignment of Benefits Form

Alumni Dental Center  
2335 Sterlington Road Suite 200  
Lexington, Ky. 40517  
859-273-5556

Date \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Patient : \_\_\_\_\_

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

Claim Group: \_\_\_\_\_

SS#/ID# \_\_\_\_\_

Do you have dual coverage:                      YES                      NO

I hereby instruct and direct \_\_\_\_\_ Insurance Company to pay  
by check made out and to :

Alumni Dental Center  
Dr. Larry Kopczyk DMD  
Dr. Brian Vieth DMD  
Dr. Tim Majors DMD

Or

If my current policy prohibits direct payment to the doctor, I hereby also instruct and  
direct you to make out the check to me and mail it as follows:

Alumni Dental Center  
2335 Sterlington Road Ste 200  
Lexington, Ky. 40517

For the professional or medical expense benefits allowable, and otherwise payable to me under my current  
insurance policy as payment toward the total charges for the professional services rendered. THIS IS A  
DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A Photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster,  
or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance company for any reason on my behalf.

Dated: \_\_\_\_\_, 2008.

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Witness