

CLAIMS TRANSMITTAL FORM

Group/Employer Name: _____ Group # _____

EMPLOYEE INFORMATION

Employee's Name: _____ - _____ - _____
 First MI Last

Employee's SS# _____ - _____ - _____

Pay Benefits for this Claim: To Insured
 To Provider of Service

Date: _____

Signature: _____

Attach this form to any Dental claims and Mail to:

TCC Benefits Administrator
P.O. Box 22557
Charleston, SC 29413
(843) 722-2115 phone
(843) 722-2866 fax