INSURED

Authorization for Signature on File

Authorization of Payment

I _____ hereby authorize the office of PARKVILLE DENTAL CENTER to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with _____.

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of PARKVILLE DENTAL CENTER.

A photocopy of this document may act as an original.

_____ _____

Today's Date Signature of Insured