PROVIDER NOMINATION FORM

Please help us by recommending your dentist or vision provider to us! If you do not see your current provider in our directory of participating providers, let us know. We will contract your provider and make every effort to recruit him or her into our growing network of participating providers.

Dental Provider ________ Vision Provider ________

Product:

Date: _________________

Your Name (optional): ______________________________

Provider Name: ____________________________________

Practice Name: ____________________________________

Address: ____

____

City:____

State: ___________________ Zip: _____________

Phone: ____

Employer Name: ___________________________________

It is always helpful when we can tell a dentist that a current patient has recommended him or her. If you place your name above, we may tell your dentist that you have us asked to contact him or her to participate.

Return to:

CompBenefits
Fax: 513-898-7331