



### Complaint Form

MEMBER ID NUMBER:	SUBSCRIBER NAME:	GROUP NUMBER:
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ADDRESS:	HOME PHONE: ( )
	WORK PHONE: ( )
	FAX: ( )

NAME AND ID NUMBER OF DENTAL OFFICE INVOLVED:
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THIS COMPLAINT RELATES TO:  Subscriber  Dependent Name \_\_\_\_\_

PLEASE EXPLAIN YOUR COMPLAINT:

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WHAT ACTION WOULD YOU LIKE GUARDIAN TO TAKE?

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MEMBER (OR LEGAL GUARDIAN) SIGNATURE	DATE:
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Please return the Complaint Form along with all related documents to the Quality of Care Liaison at the return address shown within thirty (30) days from receipt. You will receive a response to your written complaint within thirty (30) calendar days after Guardian receives the Complaint Form.

**VALID IN FLORIDA**



To: Dental Office: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_

RE: **AUTHORIZATION TO RELEASE INFORMATION**

You are hereby authorized to release to The Guardian Life Insurance Company of America (“Guardian”) and its representatives any and all information you may have concerning my dental condition, including x-rays, which you have obtained as a result of history, examination, testing, diagnosis, treatment recommendations and/or treatment.

Guardian requires this information for the purpose of resolving my written complaint.

This Authorization shall remain valid for one year from today’s date. A signed copy of this Authorization is as valid as the original.

I realize that I am entitled to have a copy of this signed Authorization and if one is requested, do acknowledge receipt thereof.

Select ONE of the following options:

- Guardian **MAY** provide the dentist(s) that is/are subject of this complaint a copy of my written complaint.
- Guardian **MAY NOT** provide the dentist(s) that is/are subject of this complaint a copy of my written complaint.

**If no choice is indicated, Guardian will understand that authorization to release a copy of this complaint is approved.**

I have read this Authorization before signing it.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Type or Print Name

\_\_\_\_\_  
Member ID Number

\_\_\_\_\_  
Date

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of incompetent patient
- Beneficiary or personal representative of deceased patient
- Spouse or person financially responsible for the patient, where the dental information is being sought for the sole purpose of processing an application for health insurance or for enrollment in a nonprofit hospital plan, a health care service plan, or an employee benefit plan, and where the patient is to be an enrolled spouse or dependent under the policy or plan.