COASTAL DENTAL, INC. GRIEVANCE FORM

Please complete the following form completely. Accurate and complete information will help Coastal to resolve your grievance promptly. Once completed the Grievance Form should be mailed to Coastal at:

Coastal Dental, Inc.
601 Daily Drive, Suite 205
Camarillo, CA 93010
ATTN: Grievance Resolution Department

You do not have to use this Grievance Form if you do not want to. You can submit your grievance to Coastal by telephone at 1-800-874-1986, or you can complete a Grievance Form on-line through Coastal's website at www.mysmiledentalplan.com.

Please write as legibly as you can.

1. Name of Grievant (in full, including middle initial):_____

2. If the Grievant is a dependent of the Subscriber (the person who signed the contract with Coastal Dental) the full name of the Subscriber (including middle initial): _____

3. Subscriber Number:_____

4. Grievant's Address and Telephone Number:
_____[street] _____[apt.]

_____[city], _____[state] _____[zip code]

( )_____[tel. no.]

5. If this grievance is prepared by someone other than the Grievant, state:

_____[full name of preparer]

_____[relationship to Grievant]

( )_____[preparer tel. no.]

6. Name of the Grievant=s Network Dentist:

_____

7. Address of Grievant's Network Dentist:

_____ [street]

_____ [city], _____ [state]

8. Describe your grievance. Be as specific and as thorough as you can. If applicable, specify the relevant date or dates when the event or events occurred. Attach additional sheets if necessary.

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G Check here if additional sheet(s) are attached. Number of additional sheets:_____