

Extra dental care when you need it most

Vouchers for dental care

Having a healthy smile isn't always as easy as you'd like it to be. Certain health conditions may result in the need for extra oral health care. And sometimes you want a second opinion to be sure you're making the right decision. That's where your dental insurance from Principal® can help. Talk with your dentist about the voucher program, which provides you and your covered dependents with the extra care you need to maintain good oral health.

How can I benefit?

- › **Periodontal program.** Members who are pregnant—or those who have diabetes or heart disease—receive scaling and root planing covered at 100% (if dentally necessary). Or, they receive one additional cleaning (routine or periodontal), subject to deductible and coinsurance.*
- › **Cancer treatment oral health program.** Members with cancer who are undergoing chemotherapy or head/neck radiation therapy receive up to three fluoride treatments every 12 months covered at 100%, plus one additional routine cleaning.*
- › **Second opinion program.** All members are eligible for second opinions from dental providers at 100%. This program makes sure they get the best advice to make an informed decision about their care.*

* Voucher benefits are applied to the benefit period maximum.

Using the voucher program

Most dentists submit the voucher on your behalf. If you need to submit it yourself, fill out the form below and follow the instructions on the back. **Important: the dentist needs to sign the form for correct claim processing.**

1 Check which voucher program applies to you.

<input type="checkbox"/> Periodontal program	Which condition(s) apply? <input type="checkbox"/> Pregnancy <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart disease	Which service was performed? <input type="checkbox"/> Routine cleaning <input type="checkbox"/> Periodontal cleaning <input type="checkbox"/> Scaling and root planing
<input type="checkbox"/> Cancer treatment oral health program	Which conditions(s) apply? <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Head/neck radiation	Which services were performed? <input type="checkbox"/> Routine cleaning <input type="checkbox"/> Fluoride treatment
<input type="checkbox"/> Second opinion program		

2 Complete this section with your dentist.

Date of service _____ Patient ID/Account number _____

Patient name _____

Dentist signature _____

Need to submit the voucher yourself?



Send these items to our address below after your dental visit:

- This completed voucher signed by your dentist
- A completed claim form from your dentist

[Principal Life Insurance Company](#)

[P.O. Box 10357](#)

[Des Moines, IA 50306-0357](#)



[principal.com](https://www.principal.com)

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