INSURED

Authorization for Signature on File

Authorization of Payment

I _____ hereby authorize the office of Donna L. Kiesel, DDS., to affix my name to any and all claims or documents as related to any and all health benefits due to me and my dependents through my employment with _____.

I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for the balance of my dental account regardless of my insurance.

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Donna L. Kiesel, DDS.

This "Signature on File" will be valid from this date and shall expire in one year. A photocopy of this document may act as an original.

_____ _____

Today's Date Signature of Insured

_____ _____

Expiration Date Witnessed By