CLAIMS TRANSMITTAL FORM

Group/Employer Name: _____Group # _____

EMPLOYEE INFORMATION

Employee's Name: _____- _____ - _____
First MI Last

Employee's SS# _____- _____ - _____

Pay Benefits for this Claim: ☐ To Insured
☐ To Provider of Service

Date: _____

Signature: _____

Attach this form to any Dental or Vision claims and Mail to:

TCC Benefits Administrator
P.O. Box 22557
Charleston, SC 29413
(843) 722-2115 phone
(843) 722-2866 fax