**GRIEVANCE FORM**

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

**The CDI Group, Inc.**
601 Daily Drive, Suite 215
Camarillo, CA 93010
ATTN: Grievance Resolution Department

You do not have to use this Grievance Form. You may submit a grievance to The CDI Group by telephone at **1-888-564-3471**, or you can complete a Grievance Form on-line at www.alliancedentalplan.com/support

Name of Grievant (in full, including middle initial):_____
Member ID Number_____

If the Grievant is a dependent of the Subscriber (the person who signed the contract with The CDI Group) the full name of the Subscriber (including middle initial):
_____

Subscriber ID Number:_____

Grievant Address and Telephone Number:
_____[Street] _____[Apt.]
_____[City], _____[State] _____[Zip Code]
(  )_____[telephone number]

If this grievance is prepared by someone other than the Grievant, state:
_____ [Name of preparer]
_____ [Relationship to Grievant]
(  )_____ [Preparer telephone number]

Name of the Grievant Network Dentist:

_____

Address of the Grievant Network Dentist:

_____ [Street]
_____ [City], _____ [State and Zip code]

Describe your grievance. Be specific and thorough. If applicable, specify the relevant date(s) when or event(s) occurred. Attach additional sheets and documentation, if necessary.

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