



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 if you do not want to. You can submit your grievance to The CDI Group by telephone at **1 833 417-6453**, or you can complete a Grievance Form on-line at www.onesmiledentalplan.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 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 as specific and as thorough as you possible. If applicable, specify the

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relevant date or dates when the event or events occurred. Attach additional sheets and documentation if necessary.

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