DO NOT USE STAPLES

PART I - TO BE COMPLETED BY EMPLOYEE

1. PATIENT NAME	1a. PATIENT ADDRESS (Street) (City) (State) (Zip Code)	2. RELATIONSHIP TO EMPLOYEE Self ☐ Spouse ☐ Child ☐ Other ☐
3. SEX M ☐ F ☐	4. PATIENT BIRTH DATE Mo. Day Year	5. IF FULL TIME STUDENT (School) (City)
6. EMPLOYEE / MEMBER / SUBSCRIBER NAME (First, Middle, Last)		
7. EMPLOYEE SOCIAL SECURITY NO.	EMPLOYEE BIRTH DATE Mo. Day Year	9. COMPANY (EMPLOYER) NAME AND ADDRESS AND/OR DIVISION AND PLANT LOCATION
8. EMPLOYEE MAILING ADDRESS (Street) (City) (State) (Zip Code)		
10. ACCOUNT / POLICY #	11. IS SPOUSE OR OTHER FAMILY MEMBER EMPLOYED? ☐ Yes ☐ No If yes, Member's Name SOCIAL SECURITY NO.	12. NAME AND ADDRESS OF SPOUSE'S OR OTHER FAMILY MEMBER'S EMPLOYER IN ITEM 11 — SPOUSE BIRTH DATE Mo. Day Year
13. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ Yes ☐ No If yes, indicate	DENTAL PLAN NAME	GROUP NO. — NAME AND ADDRESS OF CARRIER

AUTHORIZATION TO RELEASE INFORMATION - I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, treatment, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable. This authorization or a copy shall be valid for one year from the date of signature.

SIGNED (PATIENT OR PARENT IF MINOR) — DATE

AUTHORIZATION TO PAY BENEFITS TO DENTIST - I hereby authorize payment directly to the below named Dentist of the Dental Benefits otherwise payable to me.

SIGNED (EMPLOYEE) — DATE

CERTIFICATION - I certify that the foregoing information is true and correct.

SIGNED (EMPLOYEE) — DATE

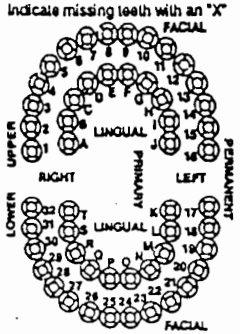
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS, FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME.

PART II - TO BE COMPLETED BY ATTENDING DENTIST

14. DENTIST NAME	22. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO ☐	YES ☐	IF YES, ENTER BRIEF DESCRIPTION AND DATES
15. MAILING ADDRESS CITY, STATE, ZIP	23. IS TREATMENT RESULT OF AUTO ACCIDENT?	☐	☐	
	24. OTHER ACCIDENT?	☐	☐	
16. TAX I.D. # TO BE USED FOR TAX REPORTING. TAX I.D. # SOC. SEC. #	25. ARE ANY SERVICES COVERED BY ANOTHER PLAN?	☐	☐	IF YES, NAME OF OTHER PLAN:
17. DENTIST LICENSE NO. 18. DENTIST PHONE NO.	26. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	☐	☐	(IF NO, REASON FOR REPLACEMENT) 27. DATE OF PRIOR PLACEMENT
19. FIRST VISIT DATE CURRENT SERIES 20. PLACE OF TREATMENT Office ☐ Hosp. ☐ ECF ☐ Other ☐ 21. RADIOGRAPHS OR MODELS ENCLOSED? ☐ Yes ☐ No HOW MANY?	28. IS TREATMENT FOR ORTHODONTICS?	☐	☐	IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED MOS TREATMENT REMAINING

CHECK ONE:
☐ PREDETERMINATION OF BENEFITS
☐ Statement of Actual Services

Indicate missing teeth with an "X"



29. EXAMINATION AND TREATMENT PLAN-LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32-USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACE (i.e., M, O, D, B, L, LA, I)	DESCRIPTION OF SERVICE (Including X-Rays, Prophylaxis, Materials Used, Etc.)	DATE SERVICE COMPLETED Mo. Day Year	PROCEDURE NUMBER (See Reverse)	FEE

30. Remarks for unusual services

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THE FEES INDICATED ARE THOSE ACTUALLY CHARGED THE PATIENT REGARDLESS OF THE EXISTENCE OF INSURANCE COVERAGE.

SIGNED (DENTIST) — DATE — TOTAL FEE CHARGED