CHECK ONE:

_____ DENTIST'S PRE-TREATMENT ESTIMATE

_____ DENTIST'S STATEMENT OF ACTUAL SERVICES

DENTAL TREATMENT PLAN AND CLAIM STATEMENT

MAIL TO: Joint Benefit Trust
4160 Dublin Blvd., Suite 400
Dublin, CA 94568-7756

PATIENT SECTION

1. PATIENT NAME — FIRST / M.I. / LAST
2. RELATIONSHIP TO INSURED — ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER
3. SEX — M | F
4. PATIENT BIRTHDATE — MO. | DAY | YEAR
5. IF FULL TIME STUDENT — SCHOOL / CITY
6. EMPLOYEE/SUBSCRIBER NAME AND MAILING ADDRESS
7. EMPLOYEE/SUBSCRIBER SOC. SEC. NUMBER
8. EMPLOYEE/SUBSCRIBER BIRTHDATE — MO. | DAY | YEAR
9. EMPLOYER (COMPANY) NAME AND ADDRESS
10. UNION LOCAL
11. IS PATIENT COVERED BY ANOTHER PLAN OF BENEFITS? — DENTAL _____ MEDICAL _____
12-A. NAME AND ADDRESS OF CARRIER(S)
12-B. GROUP NO.(S)
13. NAME AND ADDRESS OF EMPLOYER
14-A. EMPLOYEE/SUBSCRIBER NAME (IF DIFFERENT THAN PATIENT'S)
14-B. EMPLOYEE/SUBSCRIBER SOC. SEC. NUMBER
14-C. EMPLOYEE/SUBSCRIBER BIRTHDATE — MO. | DAY | YEAR
15. RELATIONSHIP TO INSURED — ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER _____

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLIAM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

▶ SIGNATURE ON FILE NOT ACCEPTABLE

SIGNED (PATIENT, OR PARENT IF MINOR) DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

▶ SIGNATURE ON FILE NOT ACCEPTABLE

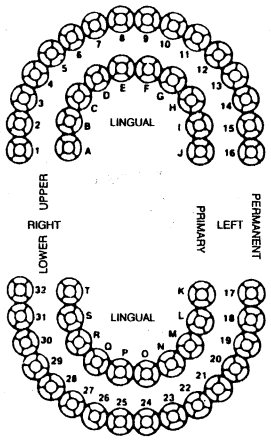
SIGNED (INSURED PERSON) DATE

DENTIST SECTION

16. DENTIST NAME
17. MAILING ADDRESS
CITY, STATE, ZIP
18. DENTIST SOC. SEC. OR T.I.N.
19. DENTIST LICENSE NO.
20. DENTIST PHONE NO.
21. FIRST VISIT DATE CURRENT SERIES
22. PLACE OF TREATMENT — OFFICE | HOSP. | ECF | OTHER
23. RADIOGRAPHS OR MODELS ENCLOSED? — NO / YES / HOW MANY?
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? — NO / YES — IF YES, ENTER BRIEF DESCRIPTION AND DATES.
25. IS TREATMENT RESULT OF AUTO ACCIDENT?
26. OTHER ACCIDENT?
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? — (IF NO, REASON FOR REPLACEMENT)
29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS? — IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED / MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"

FACIAL



FACIAL

32. REMARKS FOR UNUSUAL SERVICES

31. EXAMINATION AND TREATMENT PLAN — LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 — USING CHARTING SYSTEM SHOWN.

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICES PERFORMED MO	DAY	YEAR	ADA PROCEDURE NUMBER	FEE		FOR HSF USE ONLY
		1							
		2							
		3							
		4							
		5							
		6							
		7							
		8							
		9							
		10							
		11							
		12							
		13							
		14							
		15							
		16							
		17							
		18							
		19							
		20							
		21							

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE ACTUAL FEES I HAVE CHARGED AND INTEND TO COLLECT FOR THOSE PROCEDURES.

SIGNED (DENTIST) DATE

TOTAL FEE CHARGED	
PLAN ALLOWABLE	
DEDUCTIBLE	
PLAN %	
PLAN PAYS	
ANNUAL MAXIMUM	

IMPORTANT ALL TREATMENT PLANS IN EXCESS OF $200 REQUIRE PRE-DETERMINATION AND SUBMISSION OF DIAGNOSTIC X-RAYS