CLAIMS CONSULTANTS AND ADMINISTRATORS LTD.

THIS SECTION TO BE COMPLETED BY CLAIMANT

Name of Claimant	First	Middle Initial	Last	Address

Name of Patient	Relationship	Date of Birth			

Have you ever had this ailment before ?
Yes ☐ No ☐ If 'YES', state Date

Did the injury arise out of Patient's Employment ? Yes ☐ No ☐ If 'YES', state Date

Are you covered by any other plan providing benefits for this injury or sickness ? Yes ☐ No ☐

If 'YES' state (a) Name of Company.....

(b) Name of Group or Company insured under.....

PLEASE ATTACH STATEMENTS/BILLS FOR THE EXPENSES IN SUPPORT OF YOUR CLAIM

I hereby certify that the foregoing answers are true and correct to the best of my knowledge and hereby authorise all doctors or other persons who treated me and all hospitals or other institutions to furnish full information (including full copies of their records) regarding this claim to CLAIMS CONSULTANTS & ADMINISTRATORS LIMITED.,

ASSIGNMENT OF BENEFITS (applicable only if receipted bills are not attached). I hereby authorise payments directly to the hospital (and physician, where applicable) named on the reverse of this form, of Benefits otherwise payable to me but not to exceed the regular charges for the treatment and/or services supplied. I understand that I am financially responsible for charges not reimbursable.

....
Date Claimant's Signature

THIS SECTION MUST BE COMPLETED BY THE COMPANY

Certificate No:

Class or Code No:	Effective Date of Employee (or Dependent) Benefits Covered			

CLAIM NO:

REMARKS:

....
Signed on Behalf of Company by Title Date

Form No: 003

ATTENDING DENTIST'S STATEMENT

DENTIST'S STATEMENT OF ACTUAL SERVICES

Patient Name	Relationship to Employee	Birth Date	Date first visit (current series)

Does patient have other health coverage? Yes ☐ No ☐
If "Yes" Please identify.

Group Dental Plan name

Dentist's name (print)

Address

Telephone No.

Is any of the treatment for:
Orthodontic Purposes? Yes ☐ No ☐

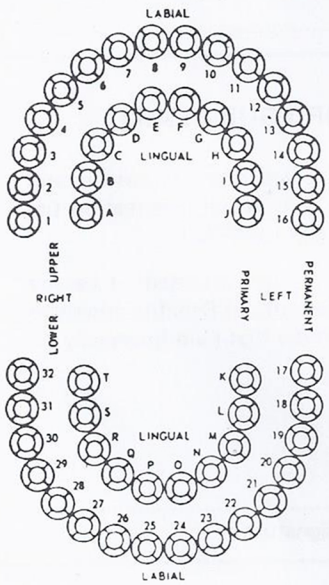
Accidental Injury
Yes ☐ No ☐

Occupational Injury?
Yes ☐ No ☐

If prosthesis, is this initial placement? Yes ☐ No ☐
If no, reason for replacement:

Date of prior placement:

Are X-rays enclosed?
Yes ☐ No ☐
If Yes, how many?



INDICATE MISSING TEETH WITH AN "X"

REMARKS FOR UNUSUAL SERVICES

Examination and treatment record – use charting system shown

Tooth # or Letter	Surfaces	Description of Service (including x-rays, prophylaxis materials used, etc.)	Date Service Performed	Fee	For Carrier Use Only

Orthodontics: *(give diagnosis, class of malocclusion and describe appliance(s) in above treatment section)*
Date first appliance inserted _____
Date last appliance removed _____
Treatment period (number months) _____
Total Fee $ _____

Total Fee Actually Charged		
Patient Pays		
Balance		
Carrier %		
Carrier Pays		

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

_____ DATE _____
Signed (Patient, or Parent if Minor)

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED

_____ DATE _____
Signed (Dentist)

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED THE CHARGES SHOWN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION.

_____ DATE _____
Signed (Insured Person)