



The United States Life Insurance Company in the City of New York

New York, New York

A member company of American International Group, Inc.

Return Claim to: P.O. Box 1581, Neptune, NJ 07754-1581

Check One:
 Dentist's pre-treatment estimate Dentist's statement of actual services

P A T I E N T S E C T I O N

1. Patient name: First _____ M.I. _____ Last _____
2. Relationship to Employee: self child spouse other _____
3. Sex: M F
4. Patient birthdate: MO _____ DAY _____ YR _____
5. If full-time student: School _____ City _____

6. Employee/Subscriber name and mailing address _____
7. Employee/Subscriber soc. sec. number _____
8. Employee/Subscriber birthdate: MM _____ DD _____ YYYY _____
9. Employer (Company) Name and Address _____
10. Group Number _____

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 _____ YR _____
15. Relationship to Patient: self child spouse other _____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

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.

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. _____

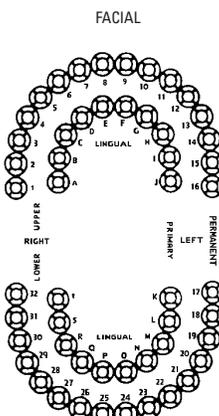
21. First visit date current series. _____
22. Place of treatment: Office Hosp. ECF. Other
23. Radiographs or models enclosed? No Yes How many? _____

24. Is treatment result of occupational illness or 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"



31. Examination and treatment plan — list in order from tooth no. 1 through tooth no. 32 — use charting system shown.

Tooth # or letter	Surface	Description of service (Including x-rays, prophylaxis, materials used, etc.) Line No.	Date service performed mo. day year	Procedure number	Fee
1			/ /		
2			/ /		
3			/ /		
4			/ /		
5			/ /		
6			/ /		
7			/ /		
8			/ /		
9			/ /		
10			/ /		
11			/ /		
12			/ /		
13			/ /		
14			/ /		
15			/ /		
16			/ /		
17			/ /		
18			/ /		
19			/ /		
20			/ /		

32. Remarks for unusual services

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	
Max. Allowable	
Deductible	
Carrier #	
Carrier pays	
Patient pays	