ATTENDING DENTIST'S STATEMENT

AMERICAN NATIONAL

CHECK ONE:

[ ] DENTIST'S PRE-TREATMENT ESTIMATE

[ ] DENTIST'S STATEMENT OF ACTUAL SERVICES

CARRIER NAME AND ADDRESS

Allied Benefit Systems, Inc. 208 S. LaSalle St, Suite 1300 Chicago, IL 60604

EDI: Payor ID 37308

PATIENT SECTION

1. Patient Name (First M.I. Last)		2. Relationship to Employee	3. Sex	4. Patient Birthdate	5. If Full Time Student
		[ ] Self [ ] Child [ ] Spouse [ ] Other_____	[ ] Male [ ] Female	MM DD YYYY	School City

6. Employee/Subscriber Name and Mailling Address		7. Employee/Subscriber Soc. Sec. Number	8. Employee/Subscriber Birthdate (MM DD YYYY)	9. Employer (Company) Name and Address	10. Group No.

11. Is Patient Covered by Another Plan of Benefits? Medical _____ Dental _____		12-A. Name and Address of Carrier(s)	12-B. Group Number(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	2. Relationship to Employee
			[ ] Self [ ] Child [ ] Spouse [ ] Other_____

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLIAIM. 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

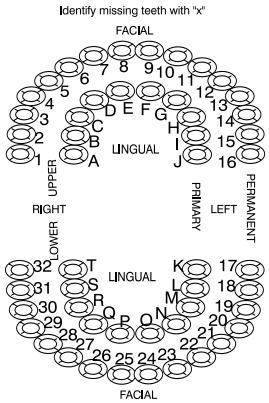
SIGNED (INSURED PERSON) _____ DATE _____

DENTIST SECTION

16. Dentist Name	24. Is Treatment Result of Occupational Illness or Injury?	No	Yes		If Yes, Enter Brief Description
17. Mailing Address	25. Is Treatment Result of Auto Accident?				
	26. Other Accident				
City, State, Zip	27. Are any services covered by another plan?				
18. Dentist SSN or TIN 19. Dentist License No. 20. Dentist Phone No.	28. If Prosthesis, is this initiatl replacement			If no, reason for replacement	29. Date of Prior Replacement

21. First Date of Current Series	22. Place of Treatment (Office Hosp. ECF Other)	23. Radiographs of Models Enclosed? How Many?	30. Is Treatment For Orthodontics?		If Services Already Commenced Enter:	Date Appliances Placed	Mos. Treatment Remaining

Identify Missing Teeth with "X"



32. Remarks for Unusual Services

31. Examination and Treatment Plan - List In Order from Tooth 1 thru Tooth 31-Use Charting System Below

Tooth # or Letter	Surface	Description of Service (Including X-Rays, Prophylaxis, Materials Used, Etc.) Line No.	Date Service Performed	Procedure Number	Fee	For Admin Use Only
		1				
		2				
		3				
		4				
		5				
		6				
		7				
		8				
		9				
		10				
		11				
		12				
		13				
		14				
		15				

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 FRO THESE PROCEDURES.

DATE _____

SIGNED (DENTIST)

***Please do not submit x-rays unless specifically requested**

TOTAL FEE CHARGED	
Max. Allowable	
Deductible	
Carrier %	
Carrier Pays	
Patient Pays	