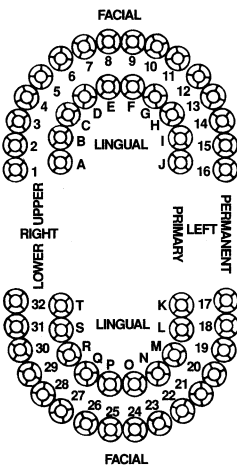


TO BE COMPLETED BY EMPLOYEE

1. PATIENT NAME			2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER		3. SEX M F	4. PATIENT BIRTHDATE MO. DAY YEAR		5. IF FULL TIME STUDENT SCHOOL CITY	
6. EMPLOYEE NAME FIRST MIDDLE LAST					7. EMPLOYEE SOCIAL SECURITY NO.		9. NAME OF GROUP DENTAL PROGRAM		
8. EMPLOYEE MAILING ADDRESS  CITY, STATE ZIP					10. EMPLOYER (COMPANY) NAME AND ADDRESS  Cal Poly Corporation HR, Building 15  San Luis Obispo, CA 93407-0705				
11. GROUP NUMBER 212	12. BRANCH	13. ARE OTHER FAMILY MEMBERS EMPLOYED? NO <input type="checkbox"/> YES <input type="checkbox"/> EMPLOYEE NAME SOC. SEC. NO.			14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13				
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? NO <input type="checkbox"/> YES <input type="checkbox"/> IF YES, GIVE		DENTAL PLAN NAME		UNION LOCAL	GROUP NO.	NAME AND ADDRESS OF CARRIER			
15a. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.  PATIENT'S SIGNATURE (PARENT IF A MINOR) DATE					15b. I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.  EMPLOYEE'S SIGNATURE DATE				

TO BE COMPLETED BY DENTIST

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

DENTIST — CHECK ONE <input type="checkbox"/> PRETREATMENT ESTIMATE <input type="checkbox"/> STATEMENT OF ACTUAL SERVICES 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							ADMINISTRATIVE USE ONLY		
	Tooth No. or Ltr.	Surface	DESCRIPTION OF SERVICES (Including X-Rays, Prophylaxis, Materials Used, etc.)	Date Service Performed			Procedure Number	FEE	BASIC	MAJOR
				Mo.	Day	Yr.				
32. REMARKS FOR UNUSUAL SERVICES										

<b>ASSIGNMENT OF BENEFITS</b>			TOTAL FEE CHARGED	
I HEREBY ASSIGN BENEFITS PAYABLE TO THE ATTENDING DENTIST.			<b>DENTAL UNIT USE</b>	
EMPLOYEE'S SIGNATURE: _____ DATE: _____			Employee Eligible Date _____	
<b>TO BE COMPLETED BY DENTIST</b>			Employee Effective Date _____	
I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE ABOVE-NAMED PATIENT ON THE DATES INDICATED:			Termination Date _____	
DENTIST'S SIGNATURE: _____ DATE: _____			Coverage Code _____	
EXAMINER _____ TRANSACTION # _____ CHECK DATE _____			Verified by _____	
			Date _____	
			Predetermination is valid for 90 days from the date above.	
			Deductible _____ Balance _____ % Payable _____ % Amt. Payable _____	
			THESE BENEFITS WILL, SUBJECT TO PLAN PROVISIONS, BE PAYABLE IF THE DESCRIBED PROCEDURES, ARE PERFORMED DURING A PERIOD OF THE PATIENT'S ELIGIBILITY. (THE PATIENT'S PERSONAL ELIGIBILITY HAS NOT BEEN VERIFIED AT THE TIME OF PREDETERMINATION.)	