ADMINISTRATOR'S STATEMENT

Group Policy No. : SP 501268 CN Certificate No: CIN 625184

Member's Occupation: Salaried Employee

Date Employed (DD/MM/YY): 02/03/16

If Patient is Member, state last date worked: 23/11/13 Hour: 9 AM/PM: AM

Has Member returned to work? If YES, When? _____ If NO, When expected? 07/05/18

Has Member made any claim for Workmen's Compensation? (YES/NO): NO Is he entitled to such benefits? (YES/NO): NO

Employer: Cisyns Services By: logical Date (DD/MM/YY): 03/09/10

THIS FORM IS TO BE COMPLETED BY THE MEMBER AND THE PLAN ADMINISTRATOR
Please answer all questions and supply all information, receipts and/or invoices.

THE ATTENDING DENTIST MUST COMPLETE THE BELOW DETAILS OF THIS FORM and attach detailed bills etc.

ATTENDING DENTIST'S STATEMENT

1. Insured Member's Name: Syed kareem pasha
2. Address: P.O.Box 1200 Route 10, Fry Key 12621
3. Patient's Name: Mia Sheik
4. Relationship to Insured Member: Wiefe
   Age: 28
5. Dentist's Name (PRINT): Kuapal Synch
6. Address: P.O.Box 2400 Route 9, Fishkill NY 12524
7. Is any of the Treatment for
   A. Orthodontic Purposes? (YES/NO): ✓
   B: Accidental Injury? (YES/NO): ✓
   C. Occupational Injury? (YES/NO): ✓
8. If Prosthesis, is this initial placement? (YES/NO): _____
   Reason for prior placement: Accident
9. Date of prior placement? (DD/MM/YY): 09/05/13
10. Are X Rays Enclosed? (YES/NO): ✓
    If "YES", how many? _____