ADMINISTRATOR'S STATEMENT

Group Policy No. : ABC-000141689AMN Certificate No: PQAQ4012568

Member's Occupation: Bussiness

Date Employed (DD/MM/YY): 07/02/17

If Patient is Member, state last date worked: _____ Hour: _____ AM/PM: _____

Has Member returned to work? If YES, When? _____ If NO, When expected? After recovery

Has Member made any claim for Workmen's Compensation? (YES/NO): Yes

Is he entitled to such benefits? (YES/NO): No

Employer: Mahesh By: _____ Date (DD/MM/YY): _____

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: Rahul
2. Address: _____
3. Patient's Name: Rahul
4. Relationship to Insured Member: Cousin

   Age: 25
5. Dentist's Name (PRINT): Vishnu
6. Address: _____
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): 24/08/10
10. Are X Rays Enclosed? (YES/NO): ✓

    If "YES", how many? _____