ADMINISTRATOR'S STATEMENT

Group Policy No. : PINO506781 Certificate No: CIN021061

Member's Occupation: Software Engineer

Date Employed (DD/MM/YY): 05/06/15

If Patient is Member, state last date worked: 05/04/15 Hour: 5 AM/PM: PM

Has Member returned to work? If YES, When? _____ If NO, When expected? 05/07/16

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

Employer: Oriental Services By: Kelly Date (DD/MM/YY): 02/03/11

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: Bin laden
2. Address: P.O.Box 61, National Church, Barbados
3. Patient's Name: Jaison Maxwell
4. Relationship to Insured Member: Husband

   Age: 34
5. Dentist's Name (PRINT): Ruth Maxwell
6. Address: P.O.Box 591 Memorial Dr, Chicopee MA1020
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): 08/10/15
10. Are X Rays Enclosed? (YES/NO): ✓

    If "YES", how many?