Authorization PLEASE SIGN AND DATE

Practitioner hereby certifies that the information provided on the Credentialing Application is true and complete and correct to the best of his or her knowledge. Practitioner hereby authorizes GEHA and its authorized representatives to contact individuals and organizations to obtain information pertaining to his or her qualifications for the credentialing and any subsequent recredentialing processes. Practitioner agrees that GEHA, its subsidiaries, employees or representatives, and individuals or organizations providing information to GEHA shall not be liable for any act or omission related to the verification of the information provided in the Credentialing Application, Attestation, or Recredentialing Application process. GEHA will treat information in the Credentialing Application, Attestation, or Recredentialing Application that is not publicly available as confidential, unless disclosure is required by law, regulation or an accrediting organization. Practitioner agrees to advise GEHA of any changes in the information provided on the Credentialing Application, Attestation, or Recredentialing Application. Practitioner understands that submission of the Credentialing Application, Attestation, or Recredentialing Application does not guarantee participation or continued participation in the Connection Dental Network. A photocopy of this page shall be considered a valid authorization.

Practitioner signature: Laine C Mabanag

Date (required): 3-27-23

Printed name: LALAINE MABANAG

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