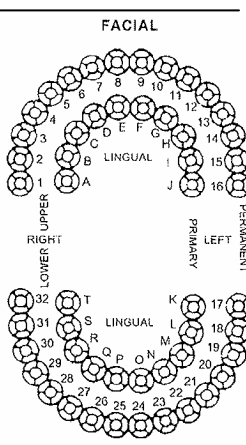




**DENTAL CLAIM FORM**  
 Claim Payment Services by  
 Pan-American Life Insurance Company  
 P.O. Box 99007  
 Lubbock, TX 79490-9007

<b>PART A - TO BE COMPLETED BY EMPLOYEE</b>											
1. PATIENT NAME (LAST, FIRST, MIDDLE)		2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER		3. SEX M F	4. PATIENT BIRTHDAY MO DAY YEAR		5. MEMBER BIRTHDAY MO DAY YEAR		6. SPOUSE BIRTHDAY MO DAY YEAR		
7. MEMBER NAME (LAST, FIRST, MIDDLE)		8. GROUP NAME		8. GROUP NUMBER			10. IF PATIENT IS FULL TIME STUDENT SCHOOL CITY				
11. MEMBER MAILING ADDRESS / IS THIS AN ADDRESS CHANGE SINCE YOUR LAST DENTAL CLAIM YES <input type="checkbox"/> NO <input type="checkbox"/>							12. MEMBER CERTIFICATE OR SS No.		13. HOME PHONE NUMBER		
CITY, STATE, ZIP				14. IS CLAIM DUE TO AN ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				15. DID ACCIDENT OCCUR AT WORK? YES <input type="checkbox"/> NO <input type="checkbox"/>			
16. IS SPOUSE EMPLOYED? YES NO SOC. SECURITY NO.				17. NAME AND ADDRESS OF EMPLOYER ITEM 16							
18. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? YES NO				NAME AND ADDRESS OF CARRIER				PLAN NO.			
I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM						I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OR THE DENTAL PLAN BENEFITS OTHERWISE PAYABLE TO ME.					
_____ SIGNED (PATIENT OR PARENT IF MINOR)						_____ SIGNED MEMBER					
_____ DATE						_____ DATE					

<b>PART B - TO BE COMPLETED BY DENTIST</b>											
19. Dentist name and phone number				27. Is Treatment result of occupational illness or injury		NO	YES	If yes , enter brief description and dates			
20. Mailing address				28. Is treatment result of auto accident							
City, State, Zip				29. Other accident							
21. Dentist Soc. Sec or PIN				30. Are any services covered by another plan.							
24. First visit date current series		25. Place of treatment Office Hosp ECF Other		26. Radiographs or models enclosed?				31. If prosthesis, is this initial placement?		(If no, reason for replacement) 32. Date of prior	
						33. Is treatment for Orthodontics				Total Fee Date appliances placed MOS Treatment Remaining	

<input type="checkbox"/> CHECK ONE: Pre- Treatment Estimate  <input type="checkbox"/> Statement of Actual Services   <p>Indicate Missing Teeth With X and Dates Extracted</p> <p>Unusual Services - Use Remarks</p>	<b>34. EXAMINATIONS AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN</b>										
	Tooth No. or Letter	Surface	DESCRIPTION OF SERVICE (Including X-Rays, Prophylaxis, materials used, etc.) Line NO.	Date service Performed Mo. Day Year	ADA Procedure No.	Fee					
<b>TOTAL FEE</b>						<b>\$</b>					
I HEREBY CERTIFY THAT SERVICE (S) LISTED ABOVE HAVE BEEN PERFORMED ON THE NAMED PATIENT ON THE DATE (S) INDICATED AND THAT THE FEES SHOWN ARE THOSE CURRENTLY CHARGED TO MY PATIENTS.											
_____ D DENTIST'S SIGNATURE						_____ DATE					

**HOW TO FILE A CLAIM FOR BENEFITS**

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>Complete "Patient Information" section.</li> <li>Sign the form.</li> <li>If payment is to be made to your dentist sign the authorization to pay him.</li> <li>Have your dentist complete the "Dentist Information" section.</li> <li>Refer complete claim and questions to:<br/>Pan American Life Insurance Company<br/>P.O. Box 619008<br/>Dallas, TX 75261-9008</li> </ul> | <p align="center"><b>PAN-AMERICAN USE</b></p> <p>Member effective date _____</p> <p>Dependent's effective date _____</p> <p>Certified by: _____</p> <p>Date: _____</p> |
|---|--|

## **NOTICE CONCERNING YOUR RIGHTS OF PRIVACY AS A CONSUMER**

Pan-American Life Insurance Company collects nonpublic information about you from the following sources:

- Information we receive from you in applications or other forms;
- Information about your transactions with us, our affiliates or others; and
- Information we receive from a consumer reporting agency.

We do not disclose any nonpublic information about our customers or former customers to anyone, except as permitted by law.

We restrict access to your nonpublic personal information to those PALIC employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

## FRAUD STATEMENTS

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho, Indiana, Kentucky, Minnesota, New Hampshire, Ohio and Oklahoma, and others require the following statement to appear on this claim form:

### **Fraud Warning**

Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

### **Fraud Warning for California Residents**

For your protection, California law requires the following to appear on this claim form:

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

### **Fraud Warning for Colorado Residents**

For your protection, Colorado law requires the following to appear on this claim form:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

### **Fraud Notice for Louisiana, Maryland and Rhode Island.**

For your protection, Louisiana, Maryland and Rhode Island law requires the following to appear on this claim form:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

### **Fraud Warning for the District of Columbia, Maine, Tennessee, Virginia and Washington Residents**

For your protection, the District of Columbia, Maine, Tennessee, Virginia and Washington law requires the following to appear on this claim form:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

### **Fraud Warning for Florida Residents**

For your protection, Florida law requires the following to appear on this claim form:

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

### **Fraud Warning for Kansas Residents**

For your protection, Kansas law requires the following to appear on this claim form:

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim or an application containing false, incomplete or misleading information may be guilty of insurance fraud as determined by a court of law.

### **Fraud Statement for New Jersey, New Mexico and Pennsylvania Residents**

For your protection, New Jersey, New Mexico and Pennsylvania law requires the following to appear on this claim form:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

### **Fraud Statement for New York Residents**

For your protection, New York law requires the following to appear on this claim form:

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

### **Fraud Statement for Puerto Rico Residents**

For your protection, Puerto Rico law requires the following to appear on this claim form:

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.