STAPLE X-RAYS FOR ALL MAJOR SERVICES TO TOP LEFT CORNER OF FORMS. X-RAYS MUST BE LABELED WITH PATIENT NAME, DENTIST NAME AND ADDRESS.

DELTA DENTAL®

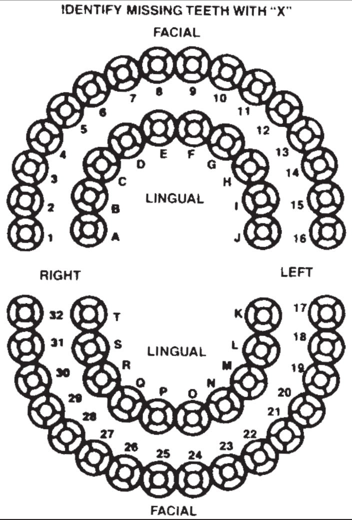
Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809
1-800-893-3582

PLEASE MAKE SURE EMPLOYEE'S MAILING ADDRESS IS LEGIBLE, CURRENT & COMPLETE

1. PATIENT NAME	2. RELATIONSHIP TO PATIENT: SELF / SPOUSE / CHILD / OTHER	3. SEX: M / F	4. PATIENT BIRTHDATE: MO. / DAY / YEAR	**5. IF FULL TIME STUDENT** SCHOOL / CITY
6. PRIMARY ENROLLEE EMPLOYEE/ NAME	FIRST / MIDDLE / LAST	**7. PRIMARY ENROLLEE ID NUMBER**	7A. PRIMARY ENR. BIRTHDATE: MO. / DAY / YEAR	9. NAME OF GROUP DENTAL PROGRAM **UT SELECT**
8. ENROLLEE MAILING ADDRESS			7B. SPOUSE BIRTHDATE: MO. / DAY / YEAR	10. EMPLOYER (COMPANY) NAME AND ADDRESS **THE UNIVERSITY OF TEXAS SYSTEM**
CITY, STATE, ZIP				
11. EMPLOYEE GROUP NUMBER **44-5968**	12. LOCATION (LOCAL)	13. ARE OTHER FAMILY MEMBERS EMPLOYED? ENROLLEE NAME / ENROLLEE ID NUMBER	14. NAME AND ADDRESS OF EMPLOYER, ITEM 13	
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN?	DENTAL PLAN NAME	UNION LOCAL	GROUP NO.	NAME AND ADDRESS OF CARRIER

		NO	YES	
16. DENTIST NAME	**24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?**			IF YES, ENTER BRIEF DESCRIPTION AND DATES
17. MAILING ADDRESS	**25. IS TREATMENT RESULT OF AUTO ACCIDENT?**			
	26. OTHER ACCIDENT?			
CITY, STATE, ZIP — **IS THIS ADDRESS NEW?** YES ❑ NO ❑	**27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?**			
18. DENTIST SOC. SEC. NO. OR T.I.N. / **19. DENTIST LICENSE NO.** / **20. DENTIST PHONE NO.**	**28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO, ENTER REASON FOR REPLACEMENT.**			**29. DATE OF PRIOR PLACEMENT**
21. FIRST VISIT DATE CURRENT SERIES / 22. PLACE OF TREATMENT: OFFICE / HOSP / ECF / OTHER / **23. RADIOGRAPHS OR MODEL ENCLOSED?** NO ❑ YES ❑ / HOW MANY?	**30. IS TREATMENT FOR ORTHODONTICS?**			**IF SERVICES ALREADY COMMENCED ENTER ⟶** **DATE APPLIANCES PLACED** / **MOS. TREATMENT REMAINING**

IDENTIFY MISSING TEETH WITH "X"



31. EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 USING CHARTING SYSTEM SHOWN.

TOOTH # OR LETTER	SURFACES	**DESCRIPTION OF SERVICE** (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	**DATE SERVICE COMPLETED** MO.	DAY	YEAR	**PROCEDURE NUMBER**	**FEE**

32. REMARKS FOR UNUSUAL SERVICES

I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATING HERETO. I CERTIFY THE TRUTH OF ALL PERSONAL INFORMATION CONTAINED ABOVE. I AGREE TO BE RESPONSIBLE FOR PAYMENT FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD.

PATIENT (PARENT OR ENROLLEE) SIGNATURE **X** ______________________

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST OF THE BENEFITS OTHERWISE PAYABLE TO ME.

X ______________________
ENROLLEE SIGNATURE DATE

TOTAL FEE CHARGED	
PATIENT PAYS	
PLAN PAYS	
AMOUNT APPLIED TO DEDUCTIBLE	

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

PREDETERMINATION OF COST

THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT AND I REQUEST PREDETERMINATION OF BENEFITS.

DENTIST SIGNATURE DATE

TREATMENT COMPLETED - PAYMENT REQUESTED

THE TREATMENT LISTED WAS COMPLETED ON DATES INDICATED AND WAS NECESSARY IN MY PROFESSIONAL JUDGMENT.

DENTIST SIGNATURE DATE

ATTENDING DENTIST'S STATEMENT

FORM 3105 (44-5968-REV. 6-06)