

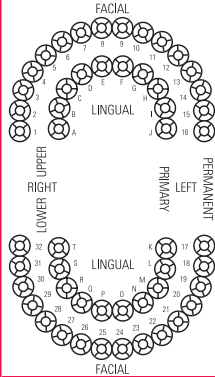
PLEASE MAKE SURE EMPLOYEE'S MAILING ADDRESS IS LEGIBLE, CURRENT & COMPLETE

1. PATIENT NAME			2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER			3. SEX M F		4. PATIENT BIRTHDATE MO. DAY YEAR			5. IF FULL TIME STUDENT OVER 18, INDICATE: SCHOOL CITY			
6. EMPLOYEE/SUBSCRIBER NAME FIRST MIDDLE LAST			7. EMPLOYEE SOCIAL SECURITY NUMBER			8. EMPLOYEE BIRTHDATE MO. DAY YEAR			9. EMPLOYEE (COMPANY) NAME AND ADDRESS/ UNION LOCAL Lockheed Martin Corporation			10. GROUP NUMBER 3001		
EMPLOYEE MAILING ADDRESS			APT. NO. PHONE NO.											
CITY, STATE, ZIP			ZIP CODE											
11. IS PATIENT COVERED BY ANOTHER PLAN OF BENEFITS? IF YES, COMPLETE ITEMS 12 THROUGH 15. YES _____ NO _____			12a. NAME AND ADDRESS OF DENTAL CARRIER(S), ITEM 11.			12b. GROUP NUMBER		13. NAME AND ADDRESS OF EMPLOYER, ITEM 11						
14a. EMPLOYEE NAME, ITEM 11 (IF DIFFERENT FROM PATIENT'S)			14b. EMPLOYEE SOCIAL SECURITY NUMBER			14c. EMPLOYEE BIRTHDATE MO. DAY YEAR		15. RELATIONSHIP TO PATIENT SELF SPOUSE CHILD OTHER						
16. DENTIST NAME			LICENSE NUMBER			24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO		YES		IF YES, ENTER DATES, BRIEF DESCRIPTION AND ANY AMOUNT PAID.		
17. MAILING ADDRESS			PHONE NO.			25. IS TREATMENT RESULT OF AUTO ACCIDENT?		NO		YES				
CITY, STATE, ZIP			ZIP CODE			26. OTHER ACCIDENT?		NO		YES				
						27. ARE ANY SERVICES COVERED BY A NON-DENTAL PLAN?		NO		YES				
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 MODELS ENCLOSED? NO <input type="checkbox"/> YES <input type="checkbox"/>		HOW MANY		30. IS TREATMENT FOR ORTHODONTICS? NO YES		IF SERVICES ALREADY COMMENCED ENTER		DATE APPLIANCES PLACED		MOS. TREATMENT REMAINING

31. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entry.

Signed (Employee/Subscriber) X _____ Date _____

IDENTIFY MISSING TEETH WITH "X" FACIAL



32. REMARKS FOR UNUSUAL SERVICES OR

AMOUNT PAID BY OTHER COVERAGE

32. EXAMINATION AND TREATMENT RECORD – LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 33. USE CHARTING SYSTEM SHOWN.

TOOTH NO. OR LETTER	SUR-FACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE COMPLETED			PROCEDURE NUMBER	FEE
			M	D	Y		
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							

MY DENTIST MAY GIVE DELTA AND ANY OTHER CARRIER NAMED ABOVE INFORMATION ABOUT MY DENTAL CONDITION OR TREATMENT NEEDED TO DETERMINE BENEFITS FOR UP TO 5 YEARS FROM THE DATE.

SIGNATURE OF PARENT
 (OR PARENT OR GUARDIAN) _____ DATE _____
You may receive a copy of this authorization on request.

PREDETERMINATION OF COST

THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGEMENT, AND I REQUEST PREDETERMINATION OF COST.

DENTIST SIGNATURE _____ DATE _____

TREATMENT COMPLETED – PAYMENT REQUESTED

THE TREATMENT LISTED WAS COMPLETED. I WILL CHARGE AND INTEND TO COLLECT THE ENTIRE PORTION OF THE FEES STATED ABOVE WHICH DELTA DETERMINES TO BE THE PATIENT'S RESPONSIBILITY, AND I WILL NOT WAIVE, REDUCE OR REBATE ANY OF THAT PORTION UNLESS I EXPRESSLY TO STATE ON THIS FORM.

DENTIST SIGNATURE _____ DATE _____

TOTAL FEE CHARGED

PATIENT PAYS

DELTA PAYS

AMOUNT APPLIED TO DEDUCTIBLE