1. ☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services

Custom Design Benefits

2. Carrier name and address
Custom Design Benefits, Inc.
5589 Cheviot Rd
Cincinnati, OH 45247

3. Patient name (first, m.i., last)	4. Relationship to employee	5. Sex	6. Patient birthdate	7. If full time student
	☐ self ☐ child ☐ spouse ☐ other _____	m f	MM DD YYYY	school city

8. Employee/subscriber name and mailing address	9. Employee/subscriber soc. sec. or ID number	10. Employee/subscriber birthdate	11. Employer and group number
			New Riegel Local School District - NRS00

12. Is patient covered by another dental plan? Yes No. If yes, complete 12a-12b. Is patient covered by a medical plan? Yes No	12a. Name and address of carrier(s)	12b. Group no.(s)	13. Name and address of other employer(s)

14a. Employee/subscriber name (if different from patient's)	14b. Employee/subscriber dental plan I.D. number	14c. Employee/subscriber birthdate MM DD YYYY	15. Relationship to patient ☐ self ☐ child ☐ spouse ☐ other _____

16. I have reviewed the following treatment plan and fees. I agree to be responsible for dental services and materials not paid by my dental benefit plan, unless the treating dentist Or dental practice has a contractual agreement with my plan prohibiting all or a portion of such Charges. To the extent permitted under applicable law, I authorize release of any information Relating to this claim.

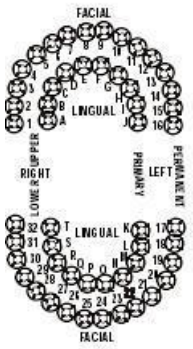
_____ _____
Signed (Patient* -- see reverse) Date

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

_____ _____
Signed (Employee/subscriber) Date

18. Name of Billing Dentist or Dental Entity	27. Is treatment result of occupational illness or injury	No	Yes	If yes, enter brief description and dates
19. Address where payment should be remitted	28. Is treatment result of auto accident?			
20. City, State, Zip	29. Other accident?			
21. Dentist Soc. Sec. or T.I.N. / 22. Dentist license no. / 23. Dentist phone no.	30. If prosthesis, is this initial placement?			If no, reason for replacement 31. Date of prior plcmt
24. First visit date current series / 25. Place of treatment: Office, Hosp., ECF, Other / 26. Radiographs or models enclosed? No Yes How many	32. Is treatment for orthodontics?			If services already commenced enter: Date placed Mos. tx remain

IDENTIFY MISSING TEETH WITH "X"



33. Examination and treatment plan – List in order from tooth no. 1 through tooth no. 32 – Using charting system shown

Tooth # or letter	Surface	Description of service (includes x-rays, prophylaxis, materials used, etc.	Date service performed Mo. Day Year	Procedure Number	Fee	For CDBI Use Only

34. Remarks for unusual services

35. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

_____ _____ _____
Signed (Treating Dentist) License Number Date

36. Total Fee Charged

37. Payment by other plan

38. Address where treatment was performed