MetLife
Metropolitan Life Insurance Company

Dental Expense Claim

To Be Completed by Employee

1. Patient First Name / Middle / Last	2. Relationship to Employee	3. Sex	4. Married?	5. Patient Date of Birth Mo. / Day / Year	6. For Office Use
	☐ Self ☐ Spouse ☐ Child ☐ Other	☐ Male ☐ Female	☐ Yes ☐ No		

7. If Full-Time Student (Age 19 or Over) School / City / State	8. ID Number	9. If Disabled (Age 19 or Over) ☐ Yes ☐ No	10. Name of Group Dental Program
			JPMorgan Chase / 14311

11. Employee First Name / Middle / Last	12. Employee Date of Birth	13. Office Phone (Area Code)

14. Employee Residence Mailing Address	15. City, State, Zip

16. Are other Family Members Employed? ☐ Yes ☐ No Name / Social Security / ID Number	17. Date of Birth	18. Name and Address of Employer for Item 16

19. Is Patient Covered by Another Dental Plan? ☐ Yes ☐ No (If Yes, complete the following:)
Dental Plan Name / Group No. / Name and Address of Carrier

20. I Authorize Release of any Information Relating to this Claim.	21. I Certify that the Above Information is Correct.	22. I Authorize Payment Directly to the Below-Named Dentist.
_____ _____ (Signature of Patient or Signature of Authorized Representative if Minor) Date _____ If Authorized Representative, Relationship to Minor	_____ _____ Employee Signature Date	_____ _____ Employee Signature Date

To Be Completed by Dentist

23. Dentist Name	24. Mailing Address / City / State / Zip			

25. Dentist Phone Number	26. Dentist License Number	27. Dentist SSN or T.I.N.	28. Provider Specialty Code	29. NPI (Treating Dentist)

30. NPI (Billing Entity, if different)	31. First Visit Date Current Series	32. Place of Treatment ☐ Office ☐ Hospital ☐ ECF ☐ Other _____	33. Radiographs or Models Enclosed? ☐ Yes ☐ No How Many? ____

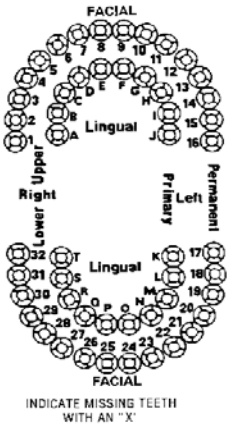
34. Is Treatment Result of Occupational Illness or Injury? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)	35. Is Treatment Result of Auto Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)

36. Other Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)	37. Are any Services Covered by Another Plan? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)

38. If Prosthesis, is this Initial Placement? ☐ Yes ☐ No (If No, Reason for Replacement)	39. Date of Prior Replacement

40. Is Treatment for Orthodontics? ☐ Yes ☐ No	If Services Already Commenced, Enter Date Appliance Placed	Months of Treatment Remaining

Dentist's – ☐ Pretreatment Estimate ☐ Statement of Actual Services *(Be sure to sign below)**



INDICATE MISSING TEETH WITH AN "X"

41. Examination and Treatment Plan – List in Order From Tooth #1 through Tooth #32 (Use Charting System Shown)

Tooth # or Letter	Surface	Description of Services (Including X-Rays, Prophylaxis, Materials Used, Etc.)	Date Service Performed Mo./ Day /Year	ADA Procedure Number	Fee	For Carrier Use Only

42. I Hereby Certify That The Services Listed Above ☐ Will Be ☐ Have Been Performed.
*Signature of Dentist _____ Date Signed _____ Total Fee Actually Charged

43. Address where treatment was performed
Street _____ City _____ State _____ Zip _____

INSTRUCTIONS

Please Review These Instructions Before Submitting Claim.

1. FRAUD WARNINGS

Before completing this form, please read the following fraud warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island, and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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

Colorado: 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.

Delaware, Idaho, Indiana, and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Florida: A 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.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maine, Tennessee, Virginia, and Washington: 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.

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

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: 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 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.

Oregon and Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Texas: 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.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.

INSTRUCTIONS (continued)

2. CLAIM SUBMISSION INFORMATION

Information for Employee

1. Complete your section of the claim form (items 1 through 21) in full to assure positive identification and prompt payment. Please print or type. Note: Item 8 (ID Number) must be completed for the claim to be processed.
2. Patient Consent. By signing item 20, the patient (or parent or other authorized representative) consents to the use and disclosure of information relating to the services provided by the dentist or health care professional for the purpose of treatment, payment, or health care operations, including submission of a claim for dental benefits to a provider or administrator of dental benefit plans. This consent will be valid for as long as the patient is entitled to coverage under a dental plan. You are entitled to a copy of this consent. This consent may be revoked in writing delivered to your dentist or health care professional, but such revocation will not affect any action taken in reliance on this consent prior to revocation. Upon receipt of revocation or refusal to sign a consent, your dentist or health care professional may decline to provide or continue treatment. If this consent is signed by the authorized representative of the patient, the relationship of the authorized representative must be provided in item 20.
3. You must sign the claim form in item 21.
4. You can arrange for MetLife to make payment directly to the dentist by completing item 22. If you wish benefits to be paid directly to yourself, do not complete item 22. In either case, a statement of benefits paid will be sent to you.
5. If total charges for the planned course of treatment are expected to be $300 or more, the form should be completed and submitted to MetLife prior to the commencement of the course of treatment for a pretreatment estimate of benefits. MetLife will notify you of your benefits payable.

   (If you wish, a pretreatment estimate may be requested for anticipated dental expenses of less than $300.)
6. If total charges for the planned course of treatment will be less than $300, the claim form should be completed when treatment is completed and mailed or faxed to the address or fax number shown below.

   Dental Coverage is subject to specific limitations and exclusions. Please refer to your booklet for a description of covered services, schedule of benefits payable, limitations and exclusions.

Information for Attending Dentist

1. Benefits are payable in accordance with four Classes of Services. It is, therefore, important that a separate fee is indicated for each item of service performed.
2. If total charges for a course of treatment are expected to be $300 or more, check the box noted "Pretreatment Estimate" and complete items 23 through 42. The completed claim form should be sent to the address shown below prior to the commencement of the course of treatment. MetLife will review the claim (and any supplementary information required) and notify your patient of the benefits payable.
3. If the address where treatment was performed is different from the mailing address in item 24, complete item 43.
4. Generally, we do *not* request x-rays where standard filling materials are used. Pre-operative x-rays are requested *only* in connection with prosthetics, fixed bridgework, or cast restorations. Occasionally, we may request x-rays that relate to other dental services.

   In an effort to reduce your costs and inconvenience, we request your cooperation in submitting x-rays *only* in the above-mentioned circumstances or when specifically requested. This will also enable us to expedite the processing of a pretreatment estimate.
5. If authorized by the employee, benefit payments will be made directly to you.

Detach and submit the completed Dental Expense Claim Form to:

MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

Fax: 1-859-389-6505

Employees' telephone: 1-888-673-9582
Dentists' telephone: 1-877-638-3379

If you are submitting a claim, please complete and detach the first page only and mail it to the above address or fax it to the number indicated. If you are requesting that the form be translated into Spanish or Chinese, please visit our website, www.metlife.com, and download the applicable claim form from our Dental Insurance Center. Or you may mail the entire four (4) pages of this form to the address shown on page 4.