SOUTHERN TIER ENVIRONMENTS FOR LIVING

Plan Sponsor & Claims Administrator
Southern Tier Environments for Living, Inc.
715 Central Avenue Dunkirk, NY 14048
Tel: (716) 366-3200 Fax: (716) 366-7840

Dental Claim Form

PATIENT SECTION

1. Patient name First MI Last	2. Relationship to employee ☐self ☐child ☐spouse ☐other_____	3. Sex M F	4. Patient birthdate MM DD YYYY	5. If full time student school city
6. Employee name and mailing address	7. Employee Soc. Sec. Number	8. Employee birthdate MM DD YYYY	9. Employer (company) name and address **Southern Tier Environments for Living, Inc.** 715 Central Ave Dunkirk, NY 14048	
10. Is patient covered by another plan of benefits? Dental _____ Medical _____	11a. Name and address of carrier(s)	11b. Group no.(s)	12. Name and address of employer	
13a. Employee/subscriber name (if different than patient's)	13b. Employee/subscriber Soc. Sec. Number	13c. Employee/subscriber birthdate MM DD YYYY	14. Relationship to patient ☐self ☐child ☐spouse ☐other _____	

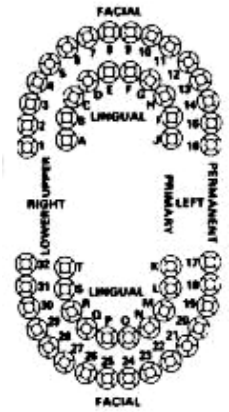
I have reviewed the following treatment plan. I authorize release of any information relating to this claim.
I understand that I am responsible for all costs of dental treatment.

_____ _____
Signed (Patient or parent if minor) Date

DENTIST SECTION

15. Dentist name	20. Is treatment result of occupational illness or Injury?	No	Yes	If yes, enter brief description and dates.	
16. Mailing address	21. Is treatment result of auto accident? 22. Other accident?				
City , State, Zip	23. Are any services covered by another plan?				
17. Telephone	24. Is any treatment/service for cosmetic purposes?				
18. First visit date current series	25. If prosthesis, is this initial placement?			If no, reason for replacement	26. Date of prior placement
19. Place of treatment ☐Office ☐Hosp. ☐ECF ☐Other _____	27. Is treatment for Orthodontics?			If services already commenced enter:	Date appliances placed: / Months treatment remaining:

Identify missing teeth with "x".



27. Examination and treatment plan–List in order from tooth 1 through tooth 32–Use charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number		Fee

28. Remarks for unusual services.

For administrative use only

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 (Dentist) Date

Total Fee Charged	
Payment made	
Balance due	

Explanation of Dental and Vision Benefits

The following is an explanation of the STEL, Inc. Dental and Vision Benefits Plan.

Southern Tier Environments for Living, Inc. (STEL, Inc.) provides a dental and vision reimbursement plan benefit to eligible employees. Our plan pays benefits based upon actual dental expenses, not a fixed dollar amount per specific procedure. Vision coverage is paid at a set dollar amount. This is not dental/vision insurance.

The Benefit Reimbursement Amount per Benefit Year (December 1st to November 30th) is as follows:

Amount of Dental Expense (Per covered person)	Employer Share	Employee Share	Plan Benefits
First $100	100%	0%	$100
Next $500	80%	20%	$400
Next $1000	50%	50%	$500

Amount of Vision Expense (Per covered person)	Employer Share	Employee Share	Plan Benefits
First $100	$100	0	$100

Claims submitted to STEL, Inc. must be accompanied by the STEL, Inc. Dental or Vision Claim Form. Claims are to be submitted to the Administrative Assistant for processing.

If you have any questions, please contact the STEL, Inc. Human Recourses Department at 716-366-3200 ext. 212 Mark Wasiewicz, HR Director or ext. 222 Sandra Maroney, Administrative Assistant.