To be completed by Participant: (Please print)	*To be completed by Flex Dept.:*
Name of FSA Participant: _____	Monthly Fees: _____
Name of Patient: _____	Beginning Date: _____
Participant SSN: _____	Ending Date: _____
Employer : _____	

ORTHODONTIC Treatment Plan

Treatment cost and insurance information:

Total cost of treatment: $_____

Less: Estimated insurance coverage: $_____

Discounts/adjustments: $_____

Total out-of-pocket cost to participant: $_____

Participant's Out-of-Pocket Expenses:

Down Payment: $_____ Due Date: _____

Monthly Payments: $_____ Start Date: _____ End Date: _____

Description of orthodontic services: _____
(use reverse side if necessary)

_____

_____ _____ _____

Signature of Orthodontist/Dentist Date Telephone Number

- *For more complete instructions, refer to the attached instruction sheet, or call us at the toll-free number listed below*
- **The FSA Participant should return this form attached to their first orthodontic claim to:**

M&I BENEFITS SERVICES
P. O. Box 2517
Appleton, WI 54912-2517

Customer Service Line: 800-236-3539 (Flex) or 920-749-3539
Fax: 888-244-2759
Web Address: www.miwebflex.com