BF&M Life INSURANCE COMPANY LIMITED
INSURANCE BUILDING • PO BOX HM 1007 • HAMILTON HM DX • BERMUDA

EMPLOYEE'S CERTIFICATE OF DENTAL HEALTH

For the purpose of securing dental expense insurance under a Group Insurance Policy issued or proposed to be issued

Name of Employer……

Full Name of Employee…….……Date of Birth……..

Names of Eligible Dependents

(1)……Relationship……Date of Birth……..……..

(2)……Relationship……Date of Birth……..……..

(3)……Relationship……Date of Birth……..……..

(4)……Relationship……Date of Birth……..……..

(5)……Relationship……Date of Birth……..……..

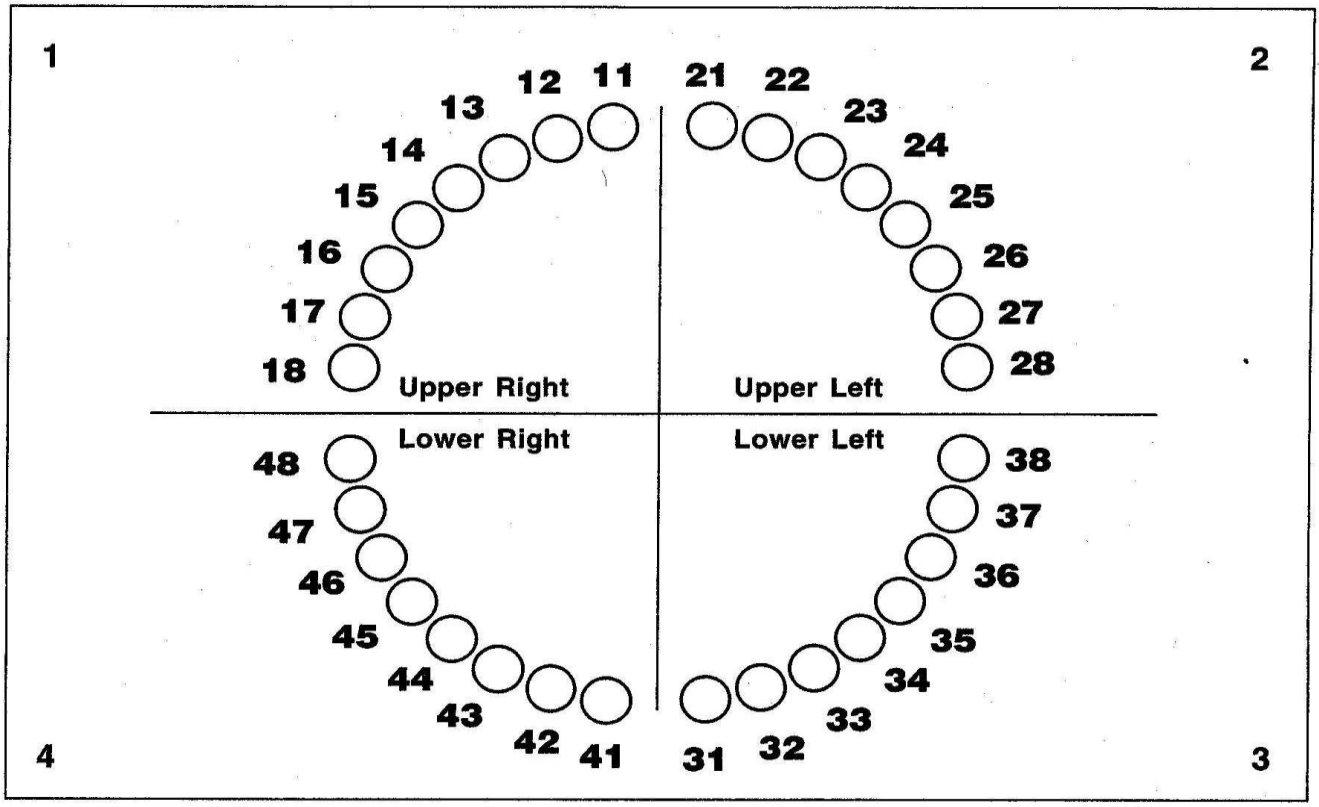
Please answer ALL questions "Yes" or "No" – DO NOT USE DASHES. Use reverse side for particulars if necessary Answer questions separately for Employee and his Dependents, if Dependent insurance is being applied for.	Re Employer	Re Dependent
1) (a) Have you or any of your dependents consulted a dentist in the last 12 months? (b) If so, describe treatment given to each family member shown above.		
2) (a) Have you or your dependents any known cavities? (b) If "Yes", indicate name of family member (c) Has a dentist recommended filling any of these cavities		
3) (a) Have you or any of your dependents had any teeth extracted that have not been replace by bridgework or other artificial teeth? (b) If "Yes" (I) identify extracted tooth/teeth for each family member (see diagram on second page) (II) has a dentist recommended replacement? (III) do you plan replacement?		
4) Have you or any of your dependents full or partial dentures? If so, what year were they fitted?		
5) (a) Are you aware of a need for any restorative dentistry (dentures, crowns, inlays, bridges or root canal therapy) for you or any of your dependents or has any restorative dentistry been recommended? (b) If "Yes", give particulars for each family member (c) Has any other form of dental treatment been advised for you or any dependents that has not yet been performed? (d) If "Yes", give particulars for each member		
6) (a) Are you or any member of your family suffering from any condition or disease of the supporting tissues of the teeth or of other parts of the mouth? (b) If "Yes", has treatment been recommended? Give particulars for each family member		
7) (a) Do you or any dependents have malformed, uneven or crooked teeth or do front teeth protrude? (b) If "Yes", give particulars for each family member (c) Has orthodontic treatment (straightening of teeth) been recommended for you for any dependents? (d) If "Yes", give particulars for each family member		
8) (a) Do you or any of you dependents expect to visit a dentist within the next 12 months for any treatment other than prophylaxis (cleaning of teeth) or regular periodic checkups? (b) If "Yes', give particulars for each family member shown above		

9) Name of Family Dentist……

I declare that the above statements and answers to questions are true and complete, and I understand and agree that if any material misrepresentation or evasion in contained herein or if any information material to the contra has not been disclosed the Company shall not be under any liability in respect of any insurance issued to me as the result of the approval of this certificate.
I hereby authorize and direct any dentist ,physician, hospital, or any person in charge of privileged documents as to my dental health or the dental health of my dependents or having knowledge of, or records as to my dental health or the dental health of my dependents, to furnish to the Company, upon request, full particulars of the knowledge or records acquired in regard to me or my dependents.

Address…….. ……..…Date……..……..

Witness…… Signature of Employee……..



Particulars to Questions

Head Office Use Only

Employee Benefits	Date of Approval d/m/y	Dependent Benefits	Date of Approval d/m/y	Group No.
	Underwriter		Underwriter	Cert. No.