

ROMAN CATHOLIC BISHOP OF SLC EMPLOYEES CAFETERIA PLAN
CONTRACT FOR ORTHODONTIC SERVICES

TO THE PLAN ADMINISTRATOR:

I _____(ORTHODONTIST) am providing orthodontic services for
_____(patient) which services are covered under the cafeteria plan for
_____(employee) at a monthly rate of \$ _____ from _____ to _____.

To the best of my knowledge, I will continue to do so until my services are no longer required.

Signature of Orthodontist

Address

I _____ (employee) SS# _____,
understand it is my responsibility to inform the Plan Administrator if the contract is terminated.

Employee signature

Date Signed