ATTACH ITEMIZED BILLS AND RETURN THIS FORM TO:

UNITED FOOD & COMMERCIAL WORKERS UNION-EMPLOYER HEALTH & WELFARE FUND

9199 Market Place, Ste. 1 • Broadview Heights, Ohio 44147
Telephone (216) 241-2828 WATS 1-800-241-2828

TO AVOID UNDUE DELAY COMPLETE ALL REQUIRED AREAS OF INFORMATION, YOUR CLAIM CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETE.

RETURN IMMEDIATELY

STATEMENT OF CLAIM FOR DENTAL BENEFITS

TO BE COMPLETED BY COVERED EMPLOYEE

1 ..... ☐ Male ☐ Female
please print last name first middle

home address

city – state – zip code

date employed | date of birth | home phone number

name of employer (firm name)

employer's address

social security number

	YES	NO	
2	☐	☐	IS THIS A DEPENDENT CLAIM? IF SO, PLEASE COMPLETE **2a**.
3	☐	☐	ARE YOU MARRIED? IF SO, PLEASE COMPLETE **3a**.
4	☐	☐	ARE YOU (OR DEPENDENT, IF A DEPENDENT CLAIM) COVERED UNDER ANY OTHER GROUP DENTAL PLAN? IF SO, PLEASE COMPLETE **4a**.
5	☐	☐	WAS THE INJURY DUE TO AN ACCIDENT? IF SO. PLEASE COMPLETE **5a**.
6	☐	☐	IS ILLNESS OR INJURY DUE TO CLAIMANT'S OCCUPATION?
7	☐	☐	ARE YOU WORKING FOR ANY OTHER EMPLOYER? IF SO PLEASE PROVIDE NAME AND ADDRESS OF OTHER EMPLOYER.

NOTICE: It is illegal to file a false or fraudulent claim or to knowingly help someone else file one. You may be fined or sent to prison for doing so. You may also be required to pay civil damages.

The above answers are true and correct to the best of my knowledge.

8 ..... employee's signature date

9 ..... spouse's signature date

NAME OF PATIENT (if other than employee)

☐ Male ☐ Female

2a full name of patient

social security number of patient

date of birth relationship to employee

COMPLETE IF MARRIED

name of spouse | effective date

name of other Insurance company or plan | other policy number

3a date of birth | spouse's social security number

name of spouse's employer | spouse's union affiliation

address of spouse's employer

city state zip code

COMPLETE IF COVERED UNDER ANY OTHER PLAN

4a name of policy holder | name of Insurance company plan

policy number | effective date

COMPLETE ONLY IF ACCIDENT OR INJURY INVOLVED

date of accident | hour (am-pm) | where did accident occur?

DESCRIBE DISABILITY.

5a

INSURED AND PATIENT MUST SIGN CONSENT TO RELEASE INFORMATION ON REVERSE SIDE OF FORM.

CONSENT FOR RELEASE OF INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, Veterans Administration Hospital, clinic, other medical or medically related facility, insurance company, consumer reporting agency or employer having information available as to diagnosis treatment and prognosis with respect to any physical or mental condition and /or treatment of me or my minor children and nay other non-medical information of me or my children to give to UFCW Union-Employer Health & Welfare Fund or its legal representative, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by UFCW Union-Employer Health & Welfare Fund or its authorized claims-paying administrator to determine eligibility for benefits or services under the Benefit Plan. Any information obtained will not be released by UFCW Union-Employer Health & Welfare Fund to any person or organization EXCEPT to re-insuring companies the Medical Information Bureau, Inc., employer, contract holder, or other persons or organization performing business or legal services in connection with my claim, or as may be otherwise lawfully required, or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of the Authorization be as valid as the original. I AGREE this Authorization shall be valid for two and one-half years from the date shown below.

PATIENT'S SIGNATURE (if other than a minor child)	INSURED'S SIGNATURE	*I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED DENTIST OR SUPPLIER FOR SERVICES DESCRIBED BELOW*
X _____	X _____ DATE _____	*SIGNED (Insured or Authorized Person)* _____

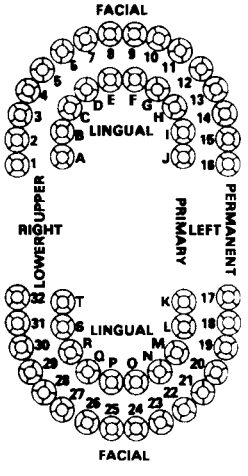
DENTIST'S INFORMATION

1. DENTIST NAME	9. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
2. MAILING ADDRESS	10 IS TREATMENT RESULT OF AUTO ACCIDENT?			
	11.OTHER ACCIDENT?			
CITY STATE ZIP	12. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
3. DENTIST SOC. SEC. OR T.I. NO. 4. DENTIST LICENSE NO. 5. DENTIST PHONE NO.	13.IF PROTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) DATE OF PRIOR PLACEMENT
6. FIRST VISIT DATE CURRENT SERIES 7. PLACE OF TREATMENT OFFICE HOSP. ECS OTHER 8. RADIOGRAPHS OR MODELS ENCLOSED NO YES HOW MANY?	14.IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED MOS. TREATMENT REMAINING

☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

X-RAYS NEEDED ON REQUEST ONLY

IDENTIFY MISSING TEETH WITH "X"



16. REMARKS FOR UNUSUAL SERVICES

15. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO.	DAY	YR.	PROCEDURE NUMBER	FEE		ADMINISTRATIVE USE

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.

_____ DATE _____
SIGNED (DENTIST)

TOTAL FEE CHARGED	
MAX. ALLOWABLE	
DEDUCTIBLE	
CARRIER %	
CARRIER PAYS	
PATIENT PAYS	

FUND OFFICE USE ONLY

ELIGIBILITY VERIFIED BY _____

DATE _____

CLAIM NUMBER _____