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

Completed Form Can Be emailed to:
hwforms@ufcw880funds.com

Member to complete Highlighted Portions Completely

1. TO BE COMPLETED BY EMPLOYEE

please print member's last name _____ first _____ middle _____

home address _____

city-state-zip code _____

date of birth _____ sex _____ occupation _____ local number _____

home phone number _____ cell phone number _____

email address _____

social security number _____

2. YES ☐ NO ☐ IS THIS A DEPENDENT CLAIM? IF SO, PLEASE COMPLETE **2a.**

3. YES ☐ NO ☐ ARE YOU MARRIED? IF SO, PLEASE COMPLETE **3a.**

4. YES ☐ NO ☐ WAS THIS DISABILITY DUE TO AN ACCIDENT OR INJURY? IF SO, PLEASE COMPLETE **4a.**

5. YES ☐ NO ☐ IS ILLNESS OR INJURY DUE TO CLAIMANT'S OCCUPATION?

6. YES ☐ NO ☐ ARE YOU WORKING FOR ANOTHER EMPLOYER? IF YES, 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.

7. _____
EMPLOYEE'S SIGNATURE **DATE**

8. _____
spouse's signature date

2a. NAME OF PATIENT (if other than employee)

full name of dependent _____

date of birth _____ sex _____ relationship _____

social security number of patient _____

name of dependent employer _____

address of dependent employer _____

city _____ state _____ zip code _____

name of policy holder _____ **name of insurance company plan** _____

policy number _____ **effective date** _____

3a. COMPLETE IF MARRIED OR COVERED UNDER ANY OTHER PLAN

name of spouse _____ date of birth _____

spouse's social security number _____

name of spouse's employer _____

address of spouse's employer _____

city _____ state _____ zip code _____

name of policy holder _____ **name of insurance company plan** _____

policy number _____ **effective date** _____

4a. PLEASE DESCRIBE ACCIDENT OR INJURY

date of injury _____ hour (am-pm) _____ where did injury occur? _____

DESCRIBE DISABILITY/CIRCUMSTANCES _____

_____

_____

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)* _____

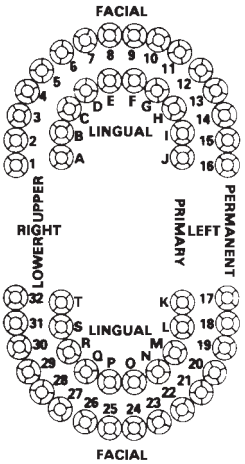
DENTIST'S INFORMATION

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?	NO ☐ YES ☐	
		11. OTHER ACCIDENT?	NO ☐ YES ☐	
CITY STATE ZIP		12. ARE ANY SERVICES COVERED BY ANOTHER PLAN?	NO ☐ YES ☐	
3. DENTIST SOC. SEC. OR T.I. NO.	4. DENTIST LICENSE NO. 5. DENTIST PHONE NO.	13. IF PROTHESIS, IS THIS INITIAL PLACEMENT?	NO ☐ YES ☐	(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? NO ☐ YES ☐ 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 _____