



Dental Claim Form

Instructions for Employee-Member

You complete the front of the form; your dentist completes the reverse; return the completed form to the above address. You may use this form or substitute a similar form from your dentist.

Pre-Treatment Estimate—Before you begin dental treatment, you may request an estimate of the benefits payable for the proposed treatment. You and your dentist complete this form, mark the box "Pre-Treatment Estimate" and return to the above address. The Benefits Fund Office will determine benefits and will forward the estimate to your dentist and to you.

Employee-Member and Claim Information—Receipt of this claim form does not guarantee payment of benefits

1. YOUR FULL NAME (EMPLOYEE-MEMBER)		MAIDEN NAME		UFCW ID# or SOCIAL SECURITY NUMBER	
2. STREET ADDRESS		CITY		STATE ZIP	
3. DAYTIME AREA CODE/PHONE NUMBER		UFCW EMPLOYER NAME		<input type="checkbox"/> MALE DATE OF BIRTH <input type="checkbox"/> FEMALE <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED DATE MARRIED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED	
4. NAME AND ADDRESS OF ANY NON-UFCW COMPANY WHERE YOU ARE ALSO EMPLOYED					
5. IS ANY PART OF TREATMENT DUE TO AN ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			IS ANY PART OF TREATMENT DUE TO PATIENT'S OCCUPATION? <input type="checkbox"/> YES <input type="checkbox"/> NO		

Spouse Information—Complete for all Claims

6. FULL NAME OF SPOUSE		DATE OF BIRTH		SOCIAL SECURITY NUMBER	
7. IF DIFFERENT FROM EMPLOYEE-MEMBER, STREET ADDRESS		CITY		STATE ZIP DAYTIME AREA CODE/PHONE NUMBER	
8. NAME AND ADDRESS OF SPOUSE'S EMPLOYER (OR FORMER EMPLOYER)				AREA CODE/PHONE NUMBER	

Dependent Child Information—Complete only if Claim is for a Dependent Child

9. DEPENDENT'S FULL NAME—FIRST AND LAST NAME		RELATIONSHIP		DATE OF BIRTH		SOCIAL SECURITY NUMBER	
10. IF DIFFERENT FROM EMPLOYEE-MEMBER, STREET ADDRESS		CITY		STATE ZIP		DAYTIME AREA CODE/PHONE NUMBER	
11. EMPLOYER NAME AND ADDRESS							CHECK <input checked="" type="checkbox"/> IF NOT EMPLOYED <input type="checkbox"/>

Other Insurance Information—Complete for all Claims

12. IS PATIENT COVERED UNDER ANY OTHER GROUP HEALTH INSURANCE OR BENEFIT PLAN, SUCH AS, GROUP BLUE CROSS, A SCHOOL PLAN, A GOVERNMENT PLAN, AN AUTO INSURANCE PLAN, ETC.? IF "YES," PLEASE PROVIDE THE INFORMATION REQUESTED BELOW. <input type="checkbox"/> YES <input type="checkbox"/> NO							
13. POLICYHOLDER'S FULL NAME—FIRST AND LAST NAME		RELATIONSHIP TO EMPLOYEE-MEMBER		DAYTIME AREA CODE/PHONE NUMBER			
14. NAME OF PLAN OR COMPANY				POLICY NUMBER			
15. ADDRESS		CITY		STATE ZIP		AREA CODE/PHONE NUMBER	

Signatures—Employee-Member and Patient (or Parent, if patient is a minor) must sign or benefits cannot be paid

I certify that the above answers and statements, including any accompanying statements, are true and complete to the best of my knowledge and belief. I authorize any dentist, physician, medical examiner or practitioner, coroner, hospital, Veterans Administration Hospital, clinic, other medical or medical-related facility, insurance or reinsuring company, consumer reporting agency, employer, school, or group policyholder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the patient for whom claim is made, to give to United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund or its legal representative, any and all such information. A photocopy of this authorization shall be as valid as the original.

Date _____ Signature _____ **Employee-Member** sign here
 Date _____ Signature _____ **Patient (or Parent)** sign here

Assignment of Benefits: Authorization to Pay Benefits to Dentist—Sign only if benefits to be paid directly to service provider

I hereby authorize payment directly to the dentist for any Dental Benefits otherwise payable to me for services in connection with this claim.
 Date _____ Employee-Member Signature _____

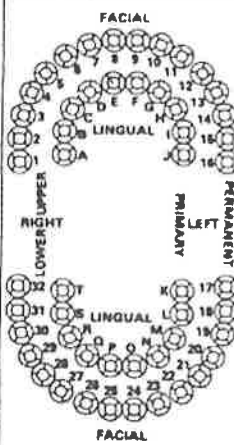
Attending Dentist's Statement

Use this form or attach a similar form of your own

Do not send radiographs or models unless specifically requested by the Benefits Office

EMPLOYEE-MEMBER NAME	UFCW ID# or SOCIAL SECURITY NUMBER	PATIENT NAME
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DENTIST NAME	DEGREE	CHECK ONE: <input type="checkbox"/> DENTIST'S PRE-TREATMENT ESTIMATE <input type="checkbox"/> DENTIST'S STATEMENT OF ACTUAL SERVICES							
MAILING ADDRESS									
CITY, STATE, ZIP									
DENTIST PHONE NO ()	DENTIST LICENSE NO	IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES ENTER BRIEF DESCRIPTION AND DATE'S				
TAX IDENTIFICATION NUMBER OR SOCIAL SECURITY NUMBER		IS TREATMENT RESULT OF AUTO ACCIDENT?							
		OTHER ACCIDENT?							
		ARE ANY SERVICES COVERED BY ANOTHER PLAN?							
MUST BE FURNISHED UNDER AUTHORITY OF LAW		IF PROSTHESIS IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) DATE OF PRIOR PLACEMENT				
FIRST VISIT DATE CURRENT SERIES	PLACE OF TREATMENT OFFICE HOSP ECF OTHER	RADIOGRAPHS OR MODELS ENCLOSED?	NO	YES	HOW MANY?	IS TREATMENT FOR ORTHODONTICS?	IF SERVICES ALREADY COMMENCED ENTER	DATE APPLIANCES PLACED	MOS TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"  <p>IF PERIODONTAL TREATMENT, INDICATE ADA CASE TYPE</p> <input type="checkbox"/> 04500 TYPE I <input type="checkbox"/> 04600 TYPE II <input type="checkbox"/> 04700 TYPE III <input type="checkbox"/> 04800 TYPE IV	EXAMINATION AND TREATMENT PLAN--LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32--USE CHARTING SYSTEM SHOWN							FOR ADMINISTRATIVE USE ONLY	
	TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC)	DATE SERVICE PERFORMED			ADA PROCEDURE NUMBER		FEE
				MO	DAY	YEAR			

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED		TOTAL FEE CHARGED
SIGNED (DENTIST) _____ DATE _____	AMOUNT PAID	
		BALANCE DUE