United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund
9801 West Higgins Road, Suite 500 ♦ Rosemont, IL 60018-4740 ♦ 847-384-7000 ♦ 800-621-5133
CUSTOMER SERVICE FAX 847-384-0196 ♦ ufcwmidwest.org

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	CHECK ☑ IF NEW ADDRESS ☐

3. DAYTIME AREA CODE/PHONE NUMBER	UFCW EMPLOYER NAME	☐ MALE ☐ FEMALE	DATE OF BIRTH	☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ MARRIED ☐ SEPARATED	DATE MARRIED

4. NAME AND ADDRESS OF ANY NON-UFCW COMPANY WHERE YOU ARE ALSO EMPLOYED

5. IS ANY PART OF TREATMENT DUE TO AN ACCIDENT? ☐ YES ☐ NO	IS ANY PART OF TREATMENT DUE TO PATIENT'S OCCUPATION? ☐ YES ☐ 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 ☑ IF NOT EMPLOYED ☐

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. ☐ YES ☐ 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 _____

— Your Dentist should complete the reverse side —

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

DENTIST NAME | DEGREE

MAILING ADDRESS

CITY, STATE, ZIP

DENTIST PHONE NO ( ) | DENTIST LICENSE NO

TAX IDENTIFICATION NUMBER
OR SOCIAL SECURITY NUMBER

MUST BE FURNISHED UNDER AUTHORITY OF LAW

CHECK ONE:

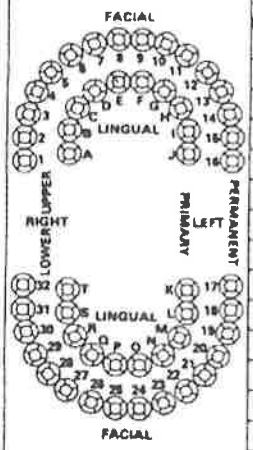
☐ **DENTIST'S PRE-TREATMENT ESTIMATE**

☐ **DENTIST'S STATEMENT OF ACTUAL SERVICES**

	NO	YES	IF YES ENTER BRIEF DESCRIPTION AND DATES
IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
IS TREATMENT RESULT OF AUTO ACCIDENT?			
OTHER ACCIDENT?			
ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
IF PROSTHESIS IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) DATE OF PRIOR PLACEMENT
IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCES PLACED MOS TREATMENT REMAINING

FIRST VISIT DATE CURRENT SERIES | PLACE OF TREATMENT: OFFICE | HOSP | ECF | OTHER | RADIOGRAPHS OR MODELS ENCLOSED? NO | YES | HOW MANY?

IDENTIFY MISSING TEETH WITH "X"



IF PERIODONTIAL TREATMENT, INDICATE ADA CASE TYPE

- ☐ 04500 TYPE I
- ☐ 04600 TYPE II
- ☐ 04700 TYPE III
- ☐ 04800 TYPE IV

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

TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO DAY YEAR	ADA PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY

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

► _____ DATE _____
SIGNED (DENTIST)

TOTAL FEE CHARGED	
AMOUNT PAID	
BALANCE DUE	