RETURN COMPLETED FORM TO:

SHEET METAL WORKERS' LOCAL 265, HEALTH & WELFARE FUND

205 Alexandra Way, Carol Stream, IL 60186-2080
Phone (630) 668-7260, 668-7291
www smw265 org - email benefits@smw265 org

DENT 1 2

DENTAL CARE BENEFITS

EMPLOYEE INFORMATION REQUIRED for all claims

Name of Employee _____ Date of Birth _____

Employee's Marital Status: Single _____ Married _____ Widowed _____ Divorced _____ Separated _____

Social Security No _____ Occupation _____ Active ☐ Retired ☐

Street, Address _____

City, State _____ Zip _____ Phone Number (_____) _____

DEPENDENT INFORMATION - If Claim Is For Your Dependent

Name of Dependent _____

Dependent's Social Security No. _____

Relationship to Employee _____ Date of Birth _____

Dependents Marital Status Single _____ Married _____ Widowed _____ Divorced _____ Separated _____

IS DEPENDENT EMPLOYED?
☐ YES ☐ NO

IF YES, Name _____
Address _____
City, State _____ Zip _____

IS DEPENDENT ATTENDING SCHOOL?
☐ YES ☐ NO

IF YES Name _____
Address _____
City, State _____ Zip _____

OTHER INSURANCE INFORMATION

Do you or your Dependent have ANY other health insurance? ☐ YES ☐ NO IF YES please supply

A) Name of the person insured _____ Relationship to Employee _____

B) Insured person's employer _____

C) Employer's street address _____

City, state _____ Zip _____

D) Policy Number _____ Certificate number _____ Social Security number _____ Phone number (_____) _____

NOTE: Attach copy of payment worksheet or denial from other insurance

ACCIDENT INFORMATION

If this treatment was required due to accidental injury, please complete Accidental Information section on other side of this form

AUTHORIZATION

I hereby certify the above statements are true and complete to the best of my knowledge and belief I authorize the release, when requested by the Trustees or their representative of any facts concerning the treatment of myself or my dependents A photocopy of this authorization shall be considered as effective and valid as the original

Employee s Signature _____ Date _____

Patient's Signature _____ Date _____

ASSIGNMENT

I hereby authorize payment of Dental Care Benefits directly to the provider(s) of services and materials described on the reverse side of this form

Employee s Signature _____

Date _____

YOU MUST SIGN FORM ON THE REVERSE SIDE

ACCIDENT INFORMATI0N

Nature of injury _____

Date accident occurred _____ Date f ı rst treated _____

Name and address of 1) _____

physician(s) consulted 2) _____

If hospitalized

Name of hospital _____ Date Admitted _____ Date Discharged _____

If injured how and where did accident happen? _____

Did injury occur in the course of any employment? ☐ YES ☐ NO

Have you or do you intend to file this claim under Workers Compensation? ☐ YES ☐ NO

TO BE COMPLETED BY DENTIST

PATIENT'S NAME _____ AGE _____

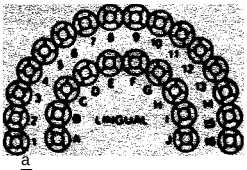
DENTIST SECTION **Use The Nomenclature And Procedure Codes Provided**

DENTIST NAME	IS TREATMENT **RESULT OF OCCUPATIONAL** ILLNESS OR INJURY?	NO	YES	*IF YES* ENTER ***BRIEF*** DESCRIPTION AND DATES
ADDRESS	**IS TREATMENT RESULT OF AUTO ACCIDENT?**			
	OTHER			
CITY STATE ZIP	**ARE ANY SERVICES COVERED BY ANOTHER PLANT**			
DENT ST S S #40 OR TAX D NO / DENTIST LICENSE NO / DENTIST PHONE NO	**IF PROSTHESIS** IS **THIS INITIAL PLACEMENT**			**IF NO, REASON FOR REPLACEMENT** **DATE OF PRIOR** REPLACEMENT
FIRST VISIT DATE / 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

NO PRE-ESTIMATE REQUIRED

INDICATE MISSING TEETH WITH AN X

FROM



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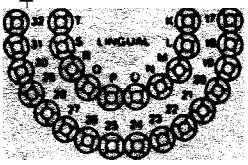
LEFT



REMARKS

IF NONE CHECK BOX ☐

EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO ı THROUGH 32

USE CHARTING SYSTEM SHOWN

Town • Opt LETTER	SLAM FACE	DESCRIPTION OF, SERVICES INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED ETC	DATE SERVICE PERFORMED MO DAY YR	PROCEDURE NUMBER	FEE	FOR FUND USE ONLY ☐ Scheduled ☐ Usual & Customary
		---				
		'''				

ORTHODONTICS Give diagnosis aim of malocclusion and describe appliance) in above treatment section)

DATE FIRST APPLIANCE _____

DATE LAST APPLIANCE REMOVED _____

TREATMENT PERIOD (NUMBER MONTHS) _____

TOTAL FEE _____

TOTAL				
DEDUCTIBLE				
TOTAL COVERED				
COPAYMENT	%	%	%	
TOTAL				
FUND PAYS	1)			
PATIENT PAYS				

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE SEEN PERFORMED ON THE DATES INDICATED

DENTIST'S SIGNATURE DATE

I HEREBY CERTIFY THAT I HAVE REVIEWED THE PLAN OF TREATMENT AND THE FEES TO ME CHARGED "IQ UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY THE PLAN-

EMPLOYEE'S SIGNATURE DATE

1) THE BENEFITS INDICATED WtLL BE PAYABLE IF THE SERVICES LISTED ARE PERFORMED WITHIN THE SAME CALENDAR YEAR AND WHILE THE PATIENT IS COVERED UNDER" THE PLAN SUBJECT TO THE PLAN PROVISIONS AND COORDINATION OF BENEFITS WITH OTHER GROUP PLANS

PATIENT MUST BE ELIGIBLE ON DATE SERVICES PERFORMED. IF TREATMENT EXTENDS BEYOND THIS DATE YOU MUST VERIFY FURTHER ELIGIBILITY WITH CLAIMS OFFICE