FOX VALLEY LABORERS HEALTH AND WELFARE FUND

2371 Bowes Road, Suite 500, Elgin, Illinois 60123-5523
847-742-0900 • 866-828-0900 (toll free) • 847-742-4430 (fax)

DENTAL CLAIM FORM

SECTION I - MEMBER'S STATEMENT and PATIENT INFORMATION *(see reverse side for instructions)*

1. MEMBER'S NAME — FIRST — MIDDLE INITIAL — LAST

2. Social Security Number ____-____-____

3. Mailing Address, Street, City, State, Zip Code — Tel. No. (   )

4. Local Union Number ____

Single — Married — Divorced

5. Patient Name: First — Middle Initial — Last

6. Relationship To Emp. — Self — Spse. — Dtr. — Son

7. Sex — M — F

8. Patient Birth Date — Mo. — Day — Yr.

9. Full time student — ☐ Yes ☐ No

10. Handicapped Child — ☐ Yes ☐ No

11. Is Patient Covered By Another Dental Plan? ☐ Yes ☐ No — If Yes, Policy Holder ID No.

12. Name and Address of Other Insurance Company

13. WAS CONDITION RELATED TO:

A. PATIENT'S EMPLOYMENT ☐ YES ☐ NO

B. AN AUTO ACCIDENT ☐ YES ☐ NO

14. DATE OF ACCIDENT ____

PLACE OF ACCIDENT ____

DESCRIPTION OF ACCIDENT ____

15. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS FOR DENTAL TREATMENT.

▶ ____ SIGNED PATIENT or PARENT IF MINOR. ____ DATE

16. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW - NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

▶ ____ SIGNED INSURED PERSON ____ DATE

SECTION II - DENTIST INFORMATION

17. Dentist Name

18. Is Treatment Result of Occupational Illness or Injury? — No — Yes — If Yes, Enter Brief Description And Dates

19. Mailing Address, Street, City, State, Zip Code

20. Is Treatment Result of Auto Accident? Other Accident?

21. Are Any Services Covered by Another Plan? — If Yes, Enter Name Of Plan

22. Dentist Soc. Sec. or T.I.N.

23. Tel. No. (   )

24. If Prosthesis, Is This Initial Placement? — (If No, Reason For Replacement) — Date of Prior Placement

25. First Visit Dt. Current Series

26. Place of Treatment — Office — Hosp — ECF — Other

27. Models Enclosed? (X-rays should be mounted) — No — Yes — How Many

28. Is Treatment For Orthodontics? — If Services Already Commenced, Enter: — Date Appliance Placed — Mos. Treatment Remaining

DENTIST'S STATEMENT I HEREBY CERTIFY THAT THE SERVICES LISTED HAVE BEEN OR WILL BE PROVIDED BY ME ▶

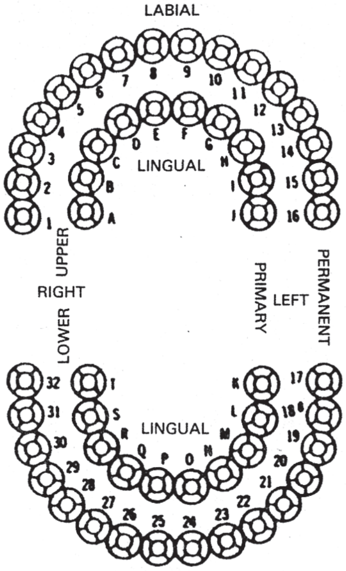
29. Dentist Signature

30. LIC NO

31. Date

32. ☐ I HAVE BEEN PAID ☐ I HAVE NOT BEEN PAID

IDENTIFY MISSING TEETH WITH "X"



X-rays not required, but must be available upon request.

EXAMINATION AND TREATMENT PLAN—LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 *(USE CHARTING SYSTEM SHOWN)*

TOOTH NO OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X—RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO DAY YR	PROCEDURE NUMBER	FEE

TOTAL FEE CHARGED

INSTRUCTIONS FOR MEMBER

Please be sure that you complete ALL of the information in Section I on the front of this form.

NOTE:

BOX 11 - If you or the patient is covered by any other group insurance policy, please provide us with the name of the insurance company, address and policy number(s).

BOX 12 - Please be sure to check either yes or no to parts A and B.

BOX 13 - If the patient's treatment is the result of an accident, please provide us with the date of the accident, place of the accident and a description of the accident.

BOX 15 - Please be sure to sign this box for the release of any information.

BOX 16 - Only sign this box if you want benefits paid directly to the provider. Do not sign this box if you want benefits paid to you.