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 ______

	YES	NO	
2.	☐	☐	IS THIS A DEPENDENT CLAIM? IF SO, PLEASE COMPLETE **2a.**
3.	☐	☐	ARE YOU MARRIED? IF SO, PLEASE COMPLETE **3a.**
4.	☐	☐	WAS THIS DISABILITY DUE TO AN ACCIDENT OR INJURY? IF SO, PLEASE COMPLETE **4a.**
5.	☐	☐	IS ILLNESS OR INJURY DUE TO CLAIMANT'S OCCUPATION?
6.	☐	☐	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.

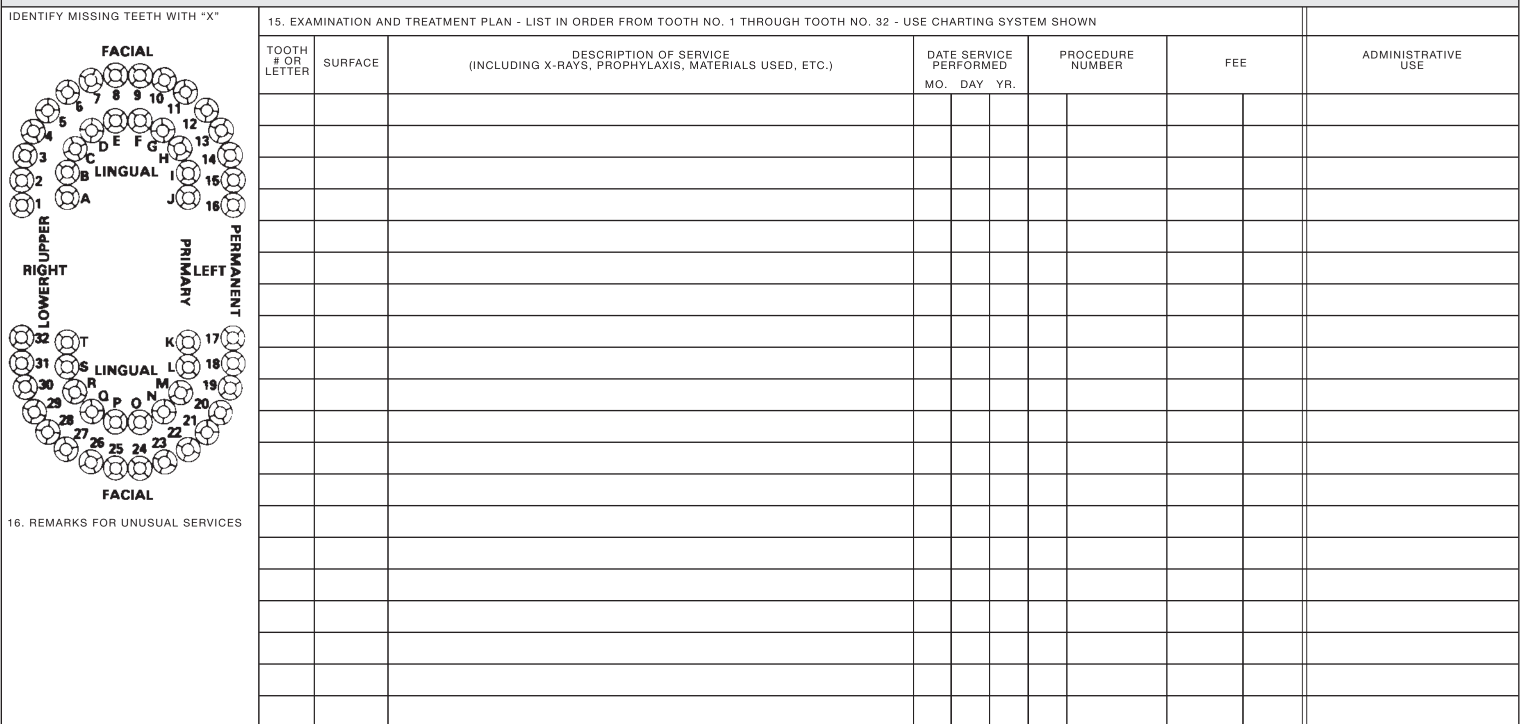
I UNDERSTAND the information obtained by use of the Authorization will be used by UFCW Union-Employer Health & Welfare Fund or its authorized claims-paying administrator to determine eligibility for benefits or services under the Benefit Plan. Any information obtained will not be released by UFCW Union-Employer 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

		NO	YES	
1. DENTIST NAME	9. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
2. MAILING ADDRESS	10. IS TREATMENT RESULT OF AUTO ACCIDENT?			
	11. OTHER ACCIDENT?			
CITY STATE ZIP	12. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
3. DENTIST SOC. SEC. OR T.I. NO. 4. DENTIST LICENSE NO. 5. DENTIST PHONE NO.	13. IF PROTHESIS, IS THIS INITIAL PLACEMENT?			(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?			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.

______________ SIGNED (DENTIST) DATE ______________

TOTAL FEE CHARGED	
MAX. ALLOWABLE	
DEDUCTIBLE	
CARRIER %	
CARRIER PAYS	
PATIENT PAYS	

FUND OFFICE USE ONLY

ELIGIBILITY VERIFIED BY ______________

DATE ______________

CLAIM NUMBER ______________