RETURN
COMPLETED
FORM TO:

IOWA LABORERS HEALTH & WELFARE FUND
150 First Ave. NE, Suite 450 - Cedar Rapids, IA 52401
Phone (319) 365-2810 - Fax (319) 365-1043

DENT. 1.1

DENTAL CARE BENEFITS

EMPLOYEE INFORMATION - REQUIRED for all claims

Home Local Union No. ________

Name of Employee ______________________ (Last) ______________________ (First) ______________________ (Middle) 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 ________

Relationship to Employee ________ Date of Birth ________

Dependent's 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 Dependents have ANY other health insurance? ☐ YES ☐ NO IF YES,

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 Benefits directly to the provider 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 INFORMATION

Nature of injury ______________________________

Date accident occurred ______________________ Date first treated ______________________

Name and address of physician(s) consulted 1) ______________________________
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 ACCIDENT?			
CITY, STATE, ZIP			ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
DENTIST S.S. NO. OR TAX ID NO.	DENTIST LICENSE NO.	DENTIST PHONE NO.	IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			IF NO, REASON FOR REPLACEMENT / DATE OF PRIOR PLACEMENT
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'

FACIAL — LINGUAL — UPPER — LOWER — RIGHT — LEFT — PRIMARY — PERMANENT — FACIAL

REMARKS:

IF NONE CHECK BOX ☐

FOR FUND USE ONLY ☐ Scheduled ☐ Usual & Customary

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

Tooth & OR Letter	SUR-FACE	DESCRIPTION OF SERVICES INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.	DATE SERVICE PERFORMED MO. DAY YR.	PROCEDURE NUMBER	FEE				

ORTHODONTICS: (give diagnosis, class of malocclusion and describe appliance(s) in above treatment section.)

DATE FIRST APPLIANCE INSERTED ______________

DATE LAST APPLIANCE REMOVED ______________

TREATMENT PERIOD (NUMBER MONTHS) ______________

TOTAL FEE ______________

TOTAL				
DEDUCTIBLE				
TOTAL COVERED				
CO PAYMENT :	%	%	%	
TOTAL				
FUND PAYS	1)			
PATIENT PAYS				

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

DENTIST'S SIGNATURE DATE:

I HEREBY CERTIFY THAT I HAVE REVIEWED THE PLAN OF TREATMENT AND THE FEES TO BE CHARGED, AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY THE PLAN.

EMPLOYEE'S SIGNATURE DATE:

1) THE BENEFITS INDICATED WILL 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.