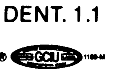
RETURN
COMPLETED
FORM TO:

SHEET METAL WORKERS LOCAL 263
HEALTH AND WELFARE FUND
150 First Avenue NE Suite 450
Cedar Rapids, IA 52401
319-365-2810

DENT. 1.1



DENTAL CARE BENEFITS

EMPLOYEE INFORMATION - REQUIRED for all claims

Home Local Union No. ________

Name of Employee ______________________________ Date of Birth ____________
(Last) (First) (Middle)

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? If YES, Name ______________________________
☐ YES ☐ NO Address ______________________________
City, State ____________________ Zip ________

Is Dependent Attending School? If YES, Name ______________________________
☐ YES ☐ NO Address ______________________________
City, State ____________________ Zip ________

OTHER INSURANCE INFORMATION

Do you **or** your Dependents have ANY other health insurance? ☐ YES ☐ NO IF YES, ☐ FAMILY ☐ SINGLE

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

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

A B C D E F G H I J

LINGUAL

UPPER RIGHT LOWER PRIMARY LEFT PERMANENT

LINGUAL

T S R Q P O N M L K

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

FACIAL

REMARKS:

IF NONE CHECK BOX ☐

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

FOR FUND USE ONLY ☐ Scheduled ☐ Usual & Customary

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.