ATTENDING DENTIST'S STATEMENT – INSURANCE CLAIM

NO PRE-ESTIMATES

SEND COMPLETED FORM TO:

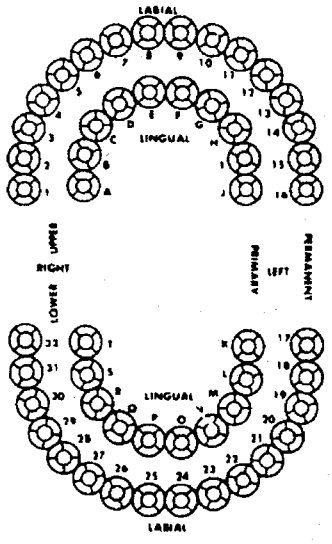
IRON WORKERS BENEFIT TRUST
MAIN P.O. BOX 398 • DAYTON, OHIO 45401-0398
PHONE: 1-800-331-4277 • FAX: 1-937-454-5457

1. IRON WORKER'S NAME	2. SOCIAL SECURITY NO.	3. IRON WORKERS BENEFIT TRUST	LOCAL #
4. IRON WORKER'S MAILING ADDRESS		5. IRON WORKER'S BIRTHDAY	SPOUSE BIRTHDAY
7. CITY, STATE, ZIP		8. AUTHORIZED SIGNATURE BY BENEFIT PLAN OFFICE	
9. PATIENT NAME	10. PATIENT RELATIONSHIP TO IRONWORKER	11. PATIENT BIRTHDAY MONTH / DAY / YEAR	12. PATIENT S.S. #

13. DENTIST NAME 14. LICENSE NO.		15. IS PATIENT COVERED BY OTHER PLAN? (NAME OTHER PLAN)		YES	NO
16. DENTIST MAILING ADDRESS 17. PHONE NUMBER		18. IS ANY OF TREATMENT FOR ORTHODONTIC PURPOSES?			
19. CITY STATE ZIP		20. TREATMENT RESULT OF ACCIDENT?			
		21. RESULT OF OCCUPATIONAL INJURY?			
22. DENTIST FEDERAL I.D. #	23. IF PROTHESIS, IS THIS INITIAL PLACEMENT? YES	NO (IF NO, REASON FOR REPLACEMENT	24. DATE OF PRIOR PLACEMENT	25. ARE X-RAYS ENCLOSED (IF YES, HOW MANY?)	

IMPORTANT — IRON WORKER MUST COMPLETE THIS SECTION BEFORE TAKING THIS FORM TO DENTIST

ARE OTHER FAMILY MEMBERS COVERED UNDER ANOTHER DENTAL PLAN ? ☐ YES ☐ NO	NAME AND ADDRESS OF EMPLOYER
IF YES, NAME OF FAMILY MEMBER — SOC. SEC. NO.	INSURANCE COMPANY NAME, ADDRESS AND PHONE NUMBER



INDICATE MISSING TEETH WITH AN 'X'

Notice: Any person, who with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

26. EXAMINATION AND TREATMENT RECORD – LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (Including X-Rays, Prophylaxis, Materials used, etc.)	DATE SERVICE PERFORMED MO	DAY	YR	PROCEDURE NUMBER	FEE	DO NOT USE THIS COLUMN
						TOTAL FEE ACTUALLY CHARGED		

BENEFITS ARE PAID TO THE PROVIDER UNLESS A PAID IN FULL RECEIPT IS ATTACHED TO THIS FORM.

I HEREBY ACCEPT THE FOREGOING TREATMENT PLAN AND AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL CHARGES NOT COVERED BY THE BENEFIT TRUST.

IRONWORKER'S SIGNATURE _____ DATE _____

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

DENTIST SIGNATURE _____ DATE _____