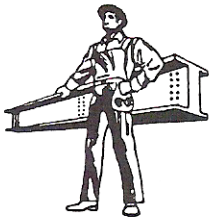


IRON WORKERS'
Tri-State Welfare Fund

953 American Lane, Suite 100,
Schaumburg, IL 60173
Toll-Free: 844-395-4467
Fax: 847-519-1979
www.tristatewelfarefund.com
tristateiron@groupadministrators.com

DENTAL CARE BENEFITS

EMPLOYEE INFORMATION – Required for all Claims

Home Local Union No. _____

Name of Employee _____ Date of Birth _____

Marital Status ○ Single ○ Married ○ Separated ○ Widowed

Social Security No. _____ Occupation _____ ○ Active ○ Retired

Street Address _____

City, State _____ Zip _____ Telephone Number _____

DEPENDENT INFORMATION — If claim is for a 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 Dependent 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 _____

Policy # _____ Certificate # _____ Social Security # _____ Phone # _____

NOTE: Attach copy of payment worksheet or denial from other insurance.

ACCIDENT INFORMATION

If this treatment was required due to accidental injury, please complete Accident Information section on the next page.

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(s) of services and materials described on the next page of this form.

Employee Signature: _____ *Date:* _____

ACCIDENT INFORMATION

Nature of Injury _____

Date accident occurred _____ Date first treated_____

Name and address of 1. _____

Physician(s) consulted 2. _____

If hospitalized, Name of hospital _____ Date admitted _____ Dated 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: _____

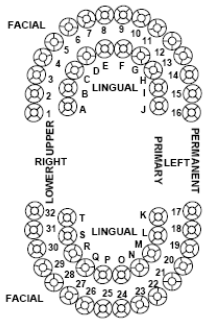
Dentist Section: Use the Nomenclature and Procedure Codes Provided

Dentist Name: _____	Is treatment result of occupational illness or injury? ❑Yes ❑No If yes, enter brief description and dates: _____
Address: _____	Is treatment result of auto accident? ❑ Yes ❑ No If yes, enter brief description and dates: _____
City, State, Zip_____	Are any services covered by another plan? ❑ Yes ❑ No

Dentist SS# or Tax ID #	Dentist License #	Dentist Phone #	If prosthesis, is this initial placement? ❑ Yes ❑ No If no, reason for replacement: _____ Date of prior placement: _____

No Pre-Estimate Required

Examination and Treatment Plan – List in Order from Tooth # 1 through 32 — Use Charting System Shown



Ir. Indicate Missing Teeth With An "X"

Tooth & OR Letter	Surface	Description of Services including x-rays, prophylaxis, material used, etc.	Date Service Performed Mo	Day	Yr	Procedure #	Fee	For Fund Use Only ❑ Scheduled ❑ Usual & Customary

Orthodontics (give diagnosis, class of malocclusion and describe appliance(s) in above treatment section
Date first appliance inserted: _____
Date last appliance removed: _____
Treatment period: _____
Total Fee: _____

Total					
Deductible					
Total Covered					
Copayment	%	%	%		
Total					
Fund Pays					
Patient Pays[1]					

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 serviced 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 SERVICE PERFORMED.
IF TREATMENT EXTENDS BEYOND THIS DATE YOU MUST VERIFY FURTHER ELIGIBILITY WITH CLAIM OFFICE.