IRON WORKERS'
Tri-State Welfare Fund

333 Pierce Road, Suite 410
Itasca, Illinois 60143
Toll-Free 866-463-9418
Fax 630-967-3080
www.tristatewelfarefund.com
tristate@abpa-tpa.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	*Assignment*
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. Member's Signature: _____ Date: _____ Patient's Signature: _____ Date: _____	*I hereby authorize payment of Dental Benefits directly to the provider(s) of services and materials described on the next page of this form.* *Member's 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: _____

Address: _____

City, State, Zip_____

Is treatment result of occupational illness or injury?❑Yes ❑No

If yes, enter brief description and dates: _____

Is treatment result of auto accident? ❑ Yes ❑ No
If yes, enter brief description and dates: _____

Are any services covered by another plan? ❑ Yes ❑ No

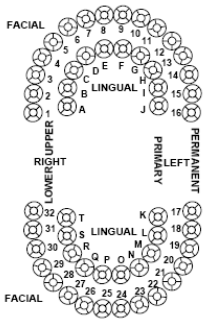
Dentist SS# or Tax ID #	Dentist License #	Dentist Phone #

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:
Member'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.