ALL QUESTIONS MUST BE COMPLETED BEFORE THE CLAIM IS SUBMITTED.

LABOR WELFARE FUND
LOCAL #363 I.B.E.W.

MAIL TO: Labor Welfare Fund
IBEW Local Union #363
67 Commerce Drive South
Harriman, NY 10926

PART 1 TO BE COMPLETED BY MEMBER

1. PATIENT NAME | 2. RELATIONSHIP TO MEMBER: SELF SPOUSE CHILD OTHER | 3. SEX: M F | 4. PATIENT BIRTHDATE: MO DAY YEAR | 5. IF FULL TIME STUDENT: SCHOOL CITY

6. MEMBERS NAME: FIRST MIDDLE LAST | 7. MEMBER SOCIAL SECURITY NO. / / | 9. NAME OF GROUP DENTAL PROGRAM: LABOR WELFARE FUND LOCAL # 363 I.B.E.W.

8. HOME ADDRESS | 10. EMPLOYER (COMPANY) NAME

CITY, STATE | ZIP | 10 a. EMPLOYER (COMPANY ADDRESS) | ZIP

11. ARE OTHER FAMILY MEMBERS EMPLOYED? NO ☐ YES ☐ | 12. EMPLOYEE NAME | 13. SOC. SEC. NO. / / | 14. NAME AND ADDRESS OF EMPLOYER IN ITEM 11

15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? NO ☐ YES ☐ | DENTAL PLAN NAME | UNION LOCAL | GROUP NO | NAME AND ADDRESS OF CARRIER

PART 2 TO BE COMPLETED BY ATTENDING DENTIST

I hereby certify to the above statements | I authorize my attending dentist to release any information relating to the claim.

MEMBER'S SIGNATURE Date | Patient's Signature (Parent if a minor) Date

16. DENTIST NAME: FIRST MIDDLE LAST

17. MAILING ADDRESS

CITY, STATE | ZIP

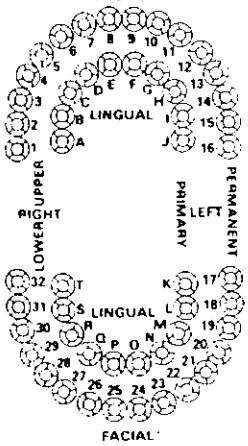
18. DENTIST SOC. SEC. OR T.I.N. | 19. DENTIST LICENSE NO | 20. DENTIST PHONE NO

21. FIRST VISIT DATE CURRENT SERIES | 22. PLACE OF TREATMENT: OFFICE HOSP. ECF OTHER | 23. RADIOGRAPHS OR MODELS ENCLOSED? NO YES HOW MANY?

	NO	YES	IF YES ENTER BRIEF DESCRIPTION AND DATES
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
26. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO REASON FOR REPLACEMENT) — 29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS?			

DENTIST — CHECK ONE
☐ PRETREATMENT ESTIMATE
☐ STATEMENT OF ACTUAL SERVICES

IDENTIFY MISSING TEETH WITH "X"



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

Tooth No. or Ltr.	Surface	DESCRIPTION OF SERVICES (Including X-Rays, Prophylaxis, Materials Used, etc.)	Date Service Performed: Mo. Day Yr.	Procedure Number	FEE	ADMINISTRATIVE USE ONLY: Eligible Amount

32. REMARKS FOR UNUSUAL SERVICES

PART 3 TOTAL FEE CHARGED

PART 4 TO BE COMPLETED BY MEMBER — IMPORTANT — READ CAREFULLY

CERTIFICATION: I hereby certify that I have reviewed the plan of treatment and the fees to be charged.

MEMBER'S SIGNATURE _____ DATE: _____

ASSIGNMENT: I hereby assign benefits payable to the attending dentist.

MEMBER'S SIGNATURE _____ DATE: _____

PART 5 TO BE COMPLETED BY DENTIST

I hereby certify that the services listed above have been performed on the above-named patient on the dates indicated:

DENTIST'S SIGNATURE: _____ DATE: _____

Date _____

Eff. Date _____ Term. Date _____ Verified By _____

ADS (75) Form approved by Council on Dental Care Programs of the ADA 1975

THIS ORIGINAL FOR OFFICE USE

OFFICE USE

MO. YR.

LIAB.
INC.

☐ MEMBER
☐ DENTIST

PAYMENT

Total Paid This Benefit Period
$ _____

These insurance benefits will, subject to policy provisions, be payable if the described procedures are performed during a period of the patient's eligibility.
(The patient's personal eligibility has not been verified at the time of predetermination).

FUND PAYS	
PATIENT PAYS	

DENTIST WILL RETAIN LAST COPY