

# ALASKA UNITED FOOD AND COMMERCIAL WORKERS HEALTH AND WELFARE TRUST

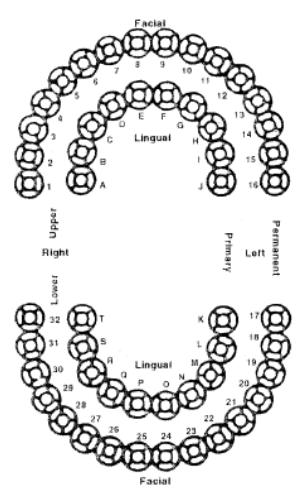
EMPLOYEE STATEMENT					
PART 1 – EMPLOYEE INFORMATION					
<input type="checkbox"/> Check here if your address is new.		EMPLOYEE NAME – First Initial Last		<input type="checkbox"/> M <input type="checkbox"/> F	EMPLOYEE WPAS ID# or SSN
EMPLOYEE BIRTH DATE		Mo. Day Year			
HOME ADDRESS	STREET	CITY	STATE	ZIP	PHONE
EMPLOYED BY					LOCAL No.
PATIENT'S NAME – First Initial Last		<input type="checkbox"/> M <input type="checkbox"/> F	PATIENT SOCIAL SECURITY NO.	PATIENT BIRTH DATE	RELATION TO EMPLOYEE
			Mo. Day Year	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
EMPLOYEE MARTIAL STATUS	IF CLAIM IS FOR DEPENDENT CHILD, PLEASE INDICATE THEIR RELATIONSHIP TO YOU			IF DEPENDENT CHILD IS AGE 19 OR OLDER, DOES HE/SHE HAVE ACCESS TO INSURANCE THROUGH HIS/HER EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> MARRIED <input type="checkbox"/> LEGAL SEP. <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVOCED	<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> ADOPTED CHILD <input type="checkbox"/> FOSTER CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> GUARDIANSHIP <input type="checkbox"/> OTHER (EXPLAIN) _____			IF YES, WAS COVERAGE DELCLINED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
			DOES CHILD HAVE A DEVELOPMENTAL DISABILITY OR PHYSICAL HANDICAP? <input type="checkbox"/> YES <input type="checkbox"/> NO		
NAME OF SPOUSE (if not patient listed above)			SPOUSE BIRTH DATE	SPOUSE SOCIAL SECURITY NO.	
			Mo. Day Year		
IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME & ADDRESS SPOUSE'S EMPLOYER		DOES SPOUSE'S EMPLOYER OFFER GROUP HEALTH INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
			DID SPOUSE DECLINE THAT COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
PART 2 – INSURANCE INFORMATION					
ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANOTHER GROUP INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO					
IF "YES", GIVE NAME AND ADDRESS OF OTHER CARRIER NAME _____ ADDRESS _____					
NAME OF SUBSCRIBER _____ SUBSCRIBER ID # OR SOCIAL SECURITY NO. _____					
OTHER GROUP PLAN COVERS: <input type="checkbox"/> PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILDREN OTHER GROUP PLAN POLICY OR ID # _____					
OTHER GROUP PLAN INCLUDES: <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION					
ARE YOU OR YOUR DEPENDENTS COVERED UNDER MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", NAME OF COVERED PERSON _____					
THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. I HEREBY AUTHORIZE MY DOCTOR TO FURNISH AND DISCLOSE ALL FACTS CONCERNING THE CLAIM.					
EMPLOYEE'S SIGNATURE X _____					DATE ____ / ____ / ____
PROCEDURE FOR FILING A CLAIM					
<b>INSTRUCTIONS TO THE EMPLOYEE:</b>					
1. Complete all applicable sections of Part 1-Employee Information and Part 2-Insurance Information. Failure to properly complete these sections may result in a delay in processing your claim.					
2. Be sure to sign where indicated on Part 2. If you want the dental benefit payment sent directly to your dentist, sign on the bottom line of Part 3 (see reverse side of this form).					
3. Complete a separate form for each patient.					
4. Take this form to your dentist on your first visit. Upon completion of treatment complete and forward the form to the address below.					
<b>INSTRUCTIONS TO THE DENTIST:</b>					
1. <b>Predetermination of cost is not required.</b>					
2. Complete Part 3-Dentist Information, answer all questions and indicate all treatment performed.					
3. Indicate on the chart all missing teeth with an "X" and all abutments with an "O".					
4. Describe procedures for treatment of this case, give the date of service and the fee charged for each procedure. The use of the standard ADA codes will expedite the processing of this claim.					
5. For payment to be made directly to the dentist, the <b>employee must sign the bottom line on the reverse side of this form.</b>					
Upon completion of treatment, return this form to:					
<b>AK UFCW TRUST</b> <b>P.O. BOX 34945</b> <b>Seattle Washington 98124-1945</b> Phone: (206) 441-7574 or 1-800-331-6158					
<b>NOTE: If you have other Group Insurance as your primary coverage, you need to submit the itemized bill AND a copy of the matching insurance payment explanation.</b>					

**PART 3 – DENTIST INFORMATION**

DENTIST NAME		TELEPHONE NUMBER		IS PATIENT COVERED BY ANOTHER PLAN? IF "YES", ENTER NAME OF OTHER PLAN		YES	NO
DENTIST MAILING ADDRESS							
CITY	STATE		ZIP	IS ANY OF THE TREATMENT FOR ORTHODONTIC PURPOSES?			
YOUR TAX IDENTIFICATION NUMBER				TREATMENT RESULT OF ACCIDENT?			
OTHER WISE YOUR SOC. SEC. NO.				TREATMENT RESULT OF OCCUPATIONAL INJURY?			
(MUST BE FURNISHED UNDER AUTHORITY OF LAW)				ARE X-RAYS ENCLOSED? IF "YES", HOW MANY?			
IF PROSTHESIS, IS THIS INITIAL?	YES	NO	IF "NO", REASON FOR REPLACEMENT			DATE PRIOR PLACEMENT MO. DAY YEAR	

CHECK ONE		(WORK COMPLETED – PAYMENT REQUESTED) THE TREATMENT LISTED BELOW WAS COMPLETED AND WAS NECESSARY IN MY JUDGEMENT.					
<input type="checkbox"/> DENTIST'S PRETREATMENT ESTIMATE		DENTIST SIGNATURE		DATE			
<input type="checkbox"/> DENTIST'S STATEMENT OF ACTUAL SERVICES							

**EXAMINATION AND TREATMENT RECORD**

DATE FIRST VISIT (CURRENT SERIES) MO. DAY YEAR	TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.)	NO. OF X-RAYS ETC.	ADA PROCEDURE NUMBER	DATE SERVICE PERFORMED MO. DAY YEAR	FEE	ADMIN. USE ONLY									
IDENTIFY MISSING TEETH WITH "X" AND ABUTMENTS WITH AN "O"																	
																	

PATIENT NAME	IF PARTIAL/DENTURE – INDICATE IMPRESSION DATE: _____ DELIVERY: _____
	IF PROSTESIS OR CROWN – INDICATE PREP DATE: _____ SEAT: _____
	IF ROOT CANAL – INDICATE START DATE: _____ FINISH: _____
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE-NAMED DENTIST OF THE GROUP DENTAL BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED CHARGES SHOWN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION.	
EMPLOYEE SIGNATURE X _____ DATE: _____	

**SEE OTHER SIDE FOR INSTRUCTIONS FOR FILING A CLAIM**

BENEFIT, CLAIMS PAYMENT AND ELIGIBILITY INFORMATION MAY BE OBTAINED FROM:  
WELFARE & PENSION ADMINISTRATION SERVICE, INC.  
PHONE: (206) 441-7574 or 1-800-331-6158  
[www.akufcwtrust.com](http://www.akufcwtrust.com)

ELIGIBILITY INFORMATION MAY ALSO BE OBTAINED FROM:  
LABOR TRUST SERVICES  
ANCHORAGE, ALASKA  
PHONE: (907) 561-5119 or 1-800-325-6532