RETURN FULLY COMPLETED FORM TO:

FOR OFFICE USE ONLY:
Effective Date_____
Date Certified_____
Verified By_____
Inside_____ Driver_____

Local 734 Welfare Fund

6643 North Northwest Hwy. • Chicago, IL 60631-1360

FOR DENTAL CLAIM INFORMATION CALL: 773-594-2810

INSTRUCTIONS: This Claim Form is to furnish the information needed to service your DENTAL Expense Claim. Please answer all questions fully.

1. Name of Member_____ Social Security No._____

2. Name of Patient_____ Date of Birth_____ Relationship to Member_____

3. Occupation_____ Where Employed, or School, if Student_____

4. Are the expenses for which this claim is being filed covered by any other Group Dental Plan? Yes ☐ No ☐

   If Yes, Give:_____
   (Name of Insurance Company or Organization)

   _____
   (Street Address) (City) (State) (Zip Code)

   _____
   (Policy No.) (Certificate No.) (Effective Date) (Name of Certificate Holder)

5. Is claim due to accident? Yes ☐ No ☐ If Yes, did accident arise out of your employment? Yes ☐ No ☐

   Give date accident occurred_____
   (Month) (Day) (Year)

   Describe how accident occurred_____

   _____

6. Dentist's Name_____

   Address_____
   (Street) (City) (State) (Zip Code)

Signature of Member

Signed X _____ Date_____

Address_____
(Street) (City) (State) (Zip Code)

IMPORTANT:

228 **HAVE YOU SIGNED THIS FORM AND ANSWERED ALL QUESTIONS?**

ATTENDING DENTIST'S STATEMENT

ADS (75)

PLEASE *DO NOT* MAIL X-RAYS UNLESS REQUESTED TO DO SO AT A LATER DATE

1. PATIENT NAME
2. RELATIONSHIP TO EMPLOYEE — Self | Spouse | Child | Other
3. SEX — M | F
4. PATIENT BIRTHDATE — Mo. | Day | Year
5. IF FULL TIME STUDENT — School | City
6. EMPLOYEE/SUBSCRIBER NAME — First | Middle | Last
7. EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NO.
8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS
   CITY, STATE, ZIP
9. NAME OF GROUP DENTAL PROGRAM
10. EMPLOYER (COMPANY) NAME AND ADDRESS
11. GROUP NO.
12. LOCATION (LOCAL)
13. ARE OTHER FAMILY MEMBERS EMPLOYED? — Employee Name | Soc. Sec. No.
14. NAME AND ADDRESS OF EMPLOYER (IN ITEM 13)
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? — Dental Plan Name | Union Local | Group No. | Name and Address of Carrier

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

Signed (Patient, or Parent if Minor) _____ Date _____

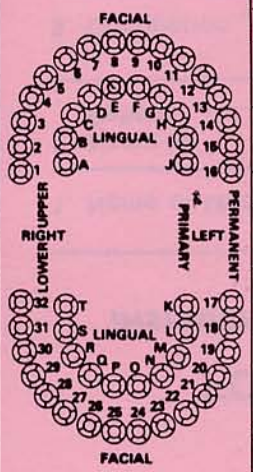
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

Signed (Insured Person) _____ Date _____

16. DENTIST NAME
17. MAILING ADDRESS
    CITY, STATE, ZIP
18. DENTIST (SOC. SEC. OR T.I.N.)
19. DENTIST LIC. NO.
20. DENTIST PHONE NO.
21. FIRST VISIT DATE CURRENT SERIES
22. PLACE OF TREATMENT — Office | Hosp. | ECF | Other
23. RADIOGRAPHS OR MODELS ENCLOSED? (Send X-rays Only When Requested) — 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?			IF SERVICES ALREADY COMMENCED ENTER — DATE APPLIANCES PLACED — MOS. TREATMENT REMAINING?

IDENTIFY MISSING TEETH WITH "X"



31. EXAMINATION & TREATMENT PLAN - LIST IN ORDER FROM TOOTH No. 1 THROUGH TOOTH No. 32 - USE CHARTING SYSTEM SHOWN

TOOTH # OR LET.	SURFACE	DESCRIPTION OF SERVICE (Including X-Rays, Prophylaxis Materials Used, etc.) LINE NO.	DATE SERVICE PERFORMED Mo. Day Year	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY

32. REMARKS FOR UNUSUAL SERVICES

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.

Signed (Dentist) _____ DATE _____

TOTAL FEE CHARGED	
MAX. ALLOWABLE	
DEDUCTIBLE	
CARRIER	
CARRIER PAYS	
PATIENT PAYS	

A DELTA DENTAL PLAN TM

LOCAL 734

FORM APPROVED BY THE COUNCIL ON DENTAL CARE PROGRAMS OF THE A.D.A. 1975