TBT SUPPLEMENTAL DENTAL PLAN CLAIM FORM

HOW TO FILE A CLAIM IF YOU HAVE PRIMARY COVERAGE UNDER THE TEAMSTERS BENEFIT TRUST SUPPLEMENTAL DENTAL PLAN: Fill out the top half of this form and arrange for your dentist to fill out the bottom half. Submit the form with the itemized dental bills and other required material such as x-rays, etc. to the TBT Plan Administration Office.

HOW TO FILE A CLAIM IF YOU HAVE PRIMARY DENTAL COVERAGE UNDER ANOTHER PLAN (SUCH AS DELTA DENTAL): Your dentist must bill the primary carrier first and send you an Explanation of Benefits (EOB) statement showing the balance owed. Fill out the top half of this form (only) and submit it with the EOB to the TBT Plan Administration Office for processing under your secondary coverage.

Teamsters Benefit Trust (TBT) • P.O. Box 5820 • Fremont, CA 94537-5820 • (510) 796-4676 • (800) 533-0119

1. Patient Name	2. Relationship to Covered Person ❑ Self ❑ Spouse ❑ Child ❑ Other:	3. Sex ❑ M ❑ F	4. Patient Birth Date *Month Day Year*	5. If claim is for a dependent student between age 21 through age 25, full-time enrollment must be documented with TBT each semester. Does this apply? ❑ No ❑ Yes

6. Covered Person's Name (Last, First, Middle Initial) *Please Print*	7. Social Security Number	8. Birth Date (Month-Day-Year)

9. Home Address *Please Print*	Apt. No.	City	State	Zip

10. Employer Name and Address/Local Union	Group Number: 1231

11. Is Patient Covered by Another Plan of Benefits ? ❑ Yes ❑ No *If Yes, Complete Items 12 Through 15*	12a. Name & Address of Dental Carrier(s) *Item 11*	12b. Group No.	13. Name & Address of Employer *Item 11*

14a. Employee Name *If Different from Patient's (Item 11)*	14b. ID Number	14c. Employee Birth Date *Month Day Year*	15. Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other:

To be Filled Out by Dentist Office

16. Dentist Name	License Number
17. Mailing Address	
City	State Zip
18. Dentist Soc. Sec. No. or T.I.N.	19. Dentist License No.
20. Dentist Phone Number	21. First Visit Date, Current Series
22. Place of Treatment ❑ Office ❑ Hospital ❑ ECR ❑ Other:	
23. Radiographs or Models Enclosed? ❑ No ❑ Yes	How Many?

If Yes to Any of the Below, Enter Dates, Brief Description and Any Amount Paid

24. Is Treatment Result of Occupational Illness or Injury? ❑ No ❑ Yes

25. Is Treatment Result of Auto Accident? ❑ No ❑ Yes

26. Other Accident? ❑ No ❑ Yes

27. Are Any Services Covered by a Non-Dental Plan? ❑ No ❑ Yes

28. If Prothesis, is This Initial Placement? (If No, Enter Reason for Replacement) ❑ No ❑ Yes

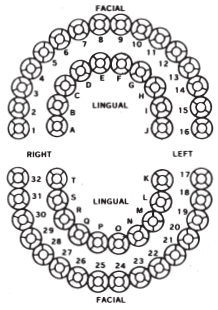
29. Date of Prior Placement

30. Is Treatment for Orthodontics? ❑ No ❑ Yes *If Services Already Commenced, Enter at Right:* →

Date Appliances Placed

Mos. Treatment Remaining

Identify Missing Teeth With "X"



31. Examination and Treatment Record—List in Order From Tooth No. 1 Through Tooth No. 32, Use Charting System Shown

Tooth No. Or Letter	Surfaces	Description of Service (Including X-Rays, Prophylaxis, Materials Used, Etc.)	Date Service Completed *Month Date Year*	Procedure Number	Fee	

32. Remarks for Unusual Services or **Amount Paid by Other Coverage**

My Dentist may give Delta and any other carrier named above information about my dental condition or treatment needed to determine benefits for up to 5 years from this date.

Signature of Patient (or Parent or Guardian) _____ *Date* _____

You may receive a copy of this authorization on request.

Total Fee Charged	
Patient Pays	
Plan Pays	

Predetermination of Cost

The treatment listed is necessary in my professional judgment and I request a predetermination of cost.

Dentist Signature _____ *Date* _____

Treatment Completed—Payment Requested

The treatment listed was completed. I will charge and intend to collect the entire portion of the fees stated above which Delta determines to be the patient's responsibility, and I will not waive, reduce or rebate any of that portion unless I expressly so state on this form.

Dentist Signature _____ *Date* _____