DENTAL CLAIM FORM

Submit within **90 days** to: **Teamsters Benefit Trust (TBT) • P.O. Box 5820 • Fremont, CA 94537-5820 • (510) 796-4676 • (800) 533-0119**

Check one: ❑ Dentist's Pre-Treatment Estimate ❑ Dentist's Statement of Actual Services

PART I — EMPLOYEE'S STATEMENT (Please type or print)

Member's Name (Last, First, Middle Initial) *Please Print*	Birth Date (Month-Day-Year)	Social Security Number
Spouse's Name (Last, First, Middle Initial) *Please Print*	Birth Date (Month-Day-Year)	Social Security Number

Patient's Name	Relationship to Employee	Birth Date (Month-Day-Year)	If Full Time Student, School Name

Home Address *Please Print*	City	State	Zip

Home Phone ( )	Local Union Number	Employee's Employer

❑ ***CHECK IF THIS IS YOUR FIRST CLAIM*** ❑ ***CHECK IF YOU HAVE MOVED SINCE YOUR LAST CLAIM***

Is Patient Covered by Any Other Dental Plan? YES ❑ NO ❑	If Answer is Yes, Complete Questions Below
Please Provide Name and Address of Patient's Other Plan or Group	Group No. or Policy No.

Name of Employer or Organization Providing Other Coverage	Name of Primary Person Covered Under Other Plan	Social Security Number of Primary Person Covered Under Other Plan

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 (Employee) Date

IMPORTANT: ONLY THE TBT PLAN ADMINISTRATION OFFICE CAN VERIFY ELIGIBILITY. A STATEMENT OF ELIGIBILITY PROVIDED BY A LOCAL UNION OR OTHER SOURCE WILL NOT BE HONORED IF IN ERROR.

PART II — AUTHORIZATION FOR RELEASE OF INFORMATION

I AUTHORIZE any, dentist, physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, consumer reporting agency, employer, union or group policyholder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, my spouse or my minor children and any other non-medical information of me, my spouse or my minor children to give to the Plan or its legal representative, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by the Plan, its Trustees or its authorized claims paying administrator to determine eligibility for benefits or services under the Plan. Any information obtained will not be released by the Plan to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., group policyholder, or other persons or organizations performing direct administrative, professional, medical or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

I UNDERSTAND that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE THIS Authorization shall be valid for the duration of my coverage under this Plan or through the third calendar year from the date shown below, whichever is earlier.

Patient's Signature	Employee's Signature	Date Signed (Month-Day-Year)

NOTE TO THE DENTIST OR PROVIDER:

This Authorization must be given to the patient or sent to the designated address at the top of this form. If you wish, you may copy the Authorization.

PART III (over) TO BE COMPLETED BY ATTENDING DENTIST ONLY.

PART III — ATTENDING DENTIST'S STATEMENT (Please type or print)

16. Dentist Name (Last, First, Middle Initial)	17. Mailing Address	City	State	Zip Code

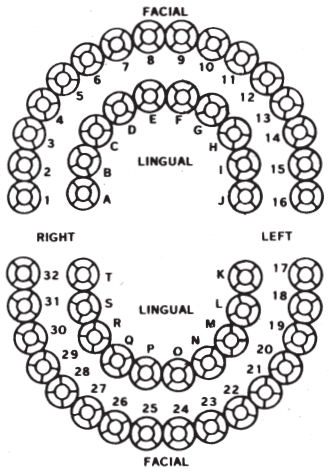
18. Dentist Social Security or TIN	19. Dentist License Number	20. Dentist Phone Number ( )

21. First Visit Date Current Series	22. Place of Treatment	23. Radiographs or Models Enclosed?
	Office ❑ Hospital ❑ Other ❑	YES ❑ NO ❑ How many?

24. Is Treatment Result of Occupational Illness or Injury?	25. Is Treatment Result of Auto Accident?
YES ❑ NO ❑ If Yes, Enter Brief Description and Date	YES ❑ NO ❑ If Yes, Enter Brief Description and Date
26. Is Treatment Result of Other Accident?	**27. Are Any Services Covered by Another Plan?**
YES ❑ NO ❑ If Yes, Enter Brief Description and Date	YES ❑ NO ❑ If Yes, Enter Name of Other Plan

28. If Prosthesis is this Initial Placement? 29. Date of Prior Placement
YES ❑ NO ❑ If No, Reason for Replacement

30. Is Treatment for Orthodontic? Date Appliances Placed Months Treatment Remaining
YES ❑ NO ❑ If Services Already Commenced Enter Here



Identify Missing Teeth with "X"

Remarks for Unusual Services

31. Examination and Treatment Plan List in Order From Tooth No. 1. Through No. 32. Use Charting System Below.

Tooth or Letter	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

I hereby certify that the procedures as indicated by date have been completed.
Dentist's Signature Date Signed (Month-Day-Year)

Total Fee Charged	
Maximum Allowable	
Deductible	
Carrier %	
Carrier Pays	
Patient Pays	

Please mail completed form to:
TEAMSTERS BENEFIT TRUST, P.O. Box 5820, Fremont, CA 94537-5820