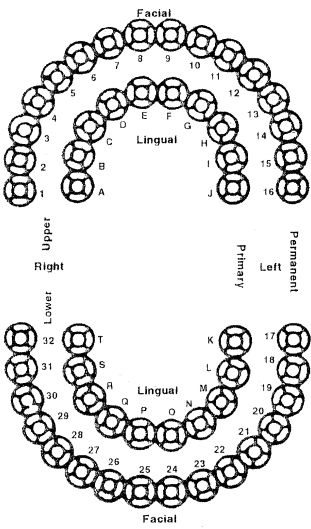


NORTHWEST IRONWORKERS
HEALTH AND SECURITY TRUST FUND

EMPLOYEE STATEMENT									
☐ Check here if your address is new.									
PART 1 - EMPLOYEE INFORMATION									
EMPLOYEE'S NAME - First Initial Last				☐ M ☐ F	EMPLOYEE SOCIAL SECURITY NUMBER			EMPLOYEE BIRTHDATE Mo. Day Year	
HOME ADDRESS		STREET		CITY		STATE		ZIP PHONE	
EMPLOYED BY								LOCAL NO.	
PATIENT'S NAME - First Initial Last				☐ M ☐ F	PATIENT SOCIAL SEC. NO.		PATIENT BIRTH DATE Mo. Day Year		RELATION TO EMPLOYEE ☐ Self ☐ Spouse ☐ Child
EMPLOYEE MARITAL STATUS ☐ MARRIED ☐ LEGAL ☐ SINGLE SEP. ☐ WIDOWED ☐ DIVORCED		IF CLAIM IS FOR DEPENDENT CHILD, PLEASE INDICATE THEIR RELATIONSHIP TO YOU ☐ NATURAL CHILD ☐ ADOPTED CHILD ☐ FOSTER CHILD ☐ STEP CHILD ☐ GUARDIANSHIP ☐ OTHER (EXPLAIN) _____			IF DEPENDENT CHILD IS AGE 19 OR OLDER, IS CHILD ENROLLED AS A FULL-TIME STUDENT? ☐ YES ☐ NO NAME OF SCHOOL _____ IF "NO", DOES CHILD HAVE A DEVELOPMENTAL DISABILITY OR PHYSICAL HANDICAP? ☐ YES ☐ NO				
NAME OF SPOUSE (if not patient listed above)					SPOUSE BIRTHDATE		SPOUSE SOCIAL SECURITY NO.		
IS SPOUSE EMPLOYED? ☐ YES ☐ NO		NAME & ADDRESS SPOUSE'S EMPLOYER							
PART 2 - INSURANCE INFORMATION									
ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANOTHER GROUP INSURANCE PLAN? ☐ YES ☐ NO									
IF "YES", GIVE NAME AND ADDRESS OF OTHER CARRIER _____									
NAME OF SUBSCRIBER _____					SUBSCRIBER SOC. SEC. NO. _____				
OTHER GROUP PLAN COVERS: ☐ PATIENT ☐ SPOUSE ☐ CHILDREN					OTHER GROUP PLAN POLICY OR I.D.# _____				
OTHER GROUP PLAN INCLUDES: ☐ MEDICAL ☐ DENTAL ☐ VISION									
ARE YOU OR YOUR DEPENDENTS COVERED UNDER MEDICARE? ☐ YES ☐ NO									
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 DISABILITY.									
EMPLOYEE'S SIGNATURE X								DATE / /	
PROCEDURE FOR FILING A CLAIM									
INSTRUCTIONS TO THE EMPLOYEE:									
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 1. 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.									
INSTRUCTIONS TO THE DENTIST:									
1. Predetermination of cost is required if proposed treatment is extensive.									
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 employee must sign the bottom line on the reverse side of this form.									
Upon completion of treatment, return this form to:									
N.W. Ironworkers Trust P.O. Box 34464 Seattle, WA 98124-1464 Phone: (206) 441-7574 or 1-800-331-6158									
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.									

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										IS ANY OF THE TREATMENT FOR ORTHODONTIC PURPOSES?								
DENTIST CITY, STATE, ZIP										TREATMENT RESULT OF ACCIDENT?								
YOUR TAX IDENTIFICATION NUMBER					OTHER WISE, YOUR SOC. SEC. NUMBER					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 JUDGMENT.					DENTIST SIGNATURE		DATE	
☐ DENTIST'S PRETREATMENT ESTIMATE ☐ DENTIST'S STATEMENT OF ACTUAL SERVICES																		
EXAMINATION AND TREATMENT RECORD																		
DATE FIRST VISIT (CURRENT SERIES)			TOOTH NO. OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.)	NO. OF X-RAYS ETC.	ADA PROCEDURE NUMBER	DATE SERVICE PERFORMED			FEE	ADMIN. USE ONLY						
MO.	DAY	YEAR						MO.	DAY	YEAR								
IDENTIFY MISSING TEETH WITH "X" 																		
IF PARTIAL/DENTURE - INDICATE START DATE: _____ DELIVERY: _____ IF PROSTHESIS 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.																		
PATIENT NAME					EMPLOYEE SIGNATURE X					DATE								

SEE OTHER SIDE FOR INSTRUCTIONS

BENEFIT, CLAIMS PAYMENT AND ELIGIBILITY INFORMATION
MAY BE OBTAINED FROM:
WELFARE & PENSION ADMIN. SERVICE
PHONE: (206) 441-7574 or 1-800-331-6158