PART I LOCAL 804 TRUST FUND • 34-21 REVIEW AVENUE • LONG ISLAND CITY, N.Y. 11101 • (718) 786-5410

Mr. ☐
Mrs. ☐
1. Miss. ☐ _____ CLMT INS. CO. USE 2. _____ FIS INS. CO. USE 3. _____

Employe's Name (First, Middle Initial, Last) | Social Security No. | Date of Birth

Ins. Co. Use / / Effective Date

4. _____ Employe's Address | City | State | Zip Code | Phone No.

5. _____ Employer's Name & Location 6. Are you still actively employed ☐ Yes ☐ No 7. This claim is for ☐ Myself ☐ My spouse ☐ My child

8. _____ Spouse's Name 9. Is Spouse employed? ☐ Yes ☐ No 10. If yes, name & address of spouse's employer _____

11. _____ Name & address of other insurance carrier providing benefits to you, your spouse or child for these expenses

12. _____ Dependent's Name (if patient) CLMT INS. CO. USE 13. / / Date of Birth 14. _____ Relationship 15. If child, is (s)he dependent on you for more than half of his/her support as defined by the U.S. Internal Revenue Code? ☐ Yes ☐ No

16. AUTHORIZATION TO RELEASE INFORMATION – I HEREBY AUTHORIZE ANY DENTIST, PHYSICIAN, HOSPITAL, INSURANCE COMPANY, ORGANIZATION OR EMPLOYER TO RELEASE ANY INFORMATION TO LOCAL 804 W.T.F., FOR ANY ORAL OR DENTAL OBSERVATION TREATMENT SERVICES OR BENEFITS RENDERED OR PAYABLE TO ME OR ON MY BEHALF. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL. SIGNED (Patient or Parent, if minor) DATE

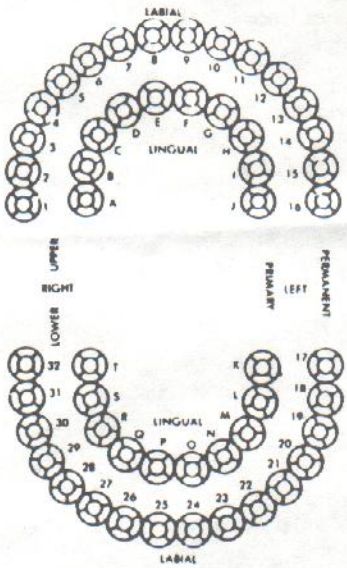
17. AUTHORIZATION TO PAY BENEFITS TO DENTISTS: I hereby authorize payment directly to the undersigned dentist of the Group Insurance Benefits otherwise payable to me SIGNED (Insured Person) DATE

RETURN TO LOCAL 804 WELFARE TRUST FUND, 34-21 REVIEW AVENUE, LONG ISLAND CITY, N.Y. 11101

PART II TO BE COMPLETED BY ATTENDING DENTIST

CHECK ONE: ☐ Dentist's Pre-Treatment Estimate ☐ Dentist's Statement of Actual Service

IF X-RAYS ARE INCLUDED STAPLE X-RAYS (NOT REQUIRED FOR AMALGAMS, PLASTICS, SILICATES) TO TOP RIGHT CORNER.



INDICATE MISSING TEETH WITH AN "X"

DATE OF FIRST VISIT (Current Series)

ARE X-RAYS ENCLOSED ☐ YES ☐ NO

IF PROTHESIS, IS THIS INITIAL PLACEMENT? ☐ YES ☐ NO

IF NO, STATE DATE OF PRIOR PLACEMENT AND REASON FOR CURRENT REPLACEMENT?

EXAMINATION AND TREATMENT RECORD · USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACE (i.e., M, O, D, B, L, LA, I)	DESCRIPTION OF SERVICES (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED Mo/D/Yr	ADA PROCEDURE NUMBER	FEE	FOR CARRIER USE ONLY ALLOWABLE FEE

Is any of the treatment due to an accidental injury? ☐ YES ☐ NO
If yes, date of injury _____ Incurred on the job? ☐ YES ☐ NO
Is any of the treatment for orthodontic purposes? ☐ YES ☐ NO

Total Fees Charged
Amount Paid
Total Allowable Fees

ORTHODONTICS: (Give diagnosis, class of malocclusion and describe appliance(s) in above treatment section)

DATE FIRST APPLIANCE INSERTED _____
DATE LAST APPLIANCE REMOVED _____
TREATMENT PERIOD (Number Months) _____
* TOTAL FEE $_____

Does patient have health or dental coverage? ___ YES ___ NO
If yes, please identify:

I hereby certify that the procedures as indicated by date of service have been performed

Dentist's Signature Date

CHECK NO: .....
DATE: .....
AMOUNT: .....
MEMBER: ☐ DENTIST: ☐

DENTIST'S NAME (Print or Type)

ADDRESS

CITY, STATE, ZIP

Individual Practitioner's Soc. Sec. No.
All Others-Employer I.D. NO.

Must be furnished under authority of law.

DENTIST'S PHONE NUMBER

PART III

I have reviewed this treatment plan, the computations and any adjustments made by

_____