WASHINGTON-IDAHO OPERATING ENGINEERS HEALTH AND SECURITY 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.	PATIENT BIRTH DATE Mo. / Year / Day	RELATION TO EMPLOYEE ☐ Self ☐ Child

EMPLOYEE MARITAL STATUS	IF CLAIM IS FOR DEPENDENT CHILD, PLEASE INDICATE THEIR RELATIONSHIP TO YOU	IF DEPENDENT CHILD IS AGE 19 OR OLDER, IS CHILD ENROLLED AS A FULL-TIME STUDENT?
☐MARRIED ☐LEGAL SEP. ☐SINGLE ☐WIDOWED ☐DIVORCED	☐NATURAL CHILD ☐ADOPTED CHILD ☐FOSTER CHILD ☐STEP CHILD ☐GUARDIANSHIP ☐OTHER (EXPLAIN)	YES☐ NO☐ NAME OF SCHOOL IF "NO" DOES CHILD HAVE A DEVELEOPMENTAL DISBILITY OR PHYSICAL HANDICAP? ☐YES ☐NO

NAME OF SPOUSE (If 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 DIS-CLOSE 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:

WA-ID OPERATING ENGINEERS
P.O. Box 34567
Seattle, WA 98124-1567
Phone: (800) 351-6480

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		RESULT OF OCCUPATIONAL INJURY?	☐ ☐
OTHER WISE, YOUR SOC. SEC. NUMBER (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

☐ DENTIST'S PRETREATMENT ESTIMATE

☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

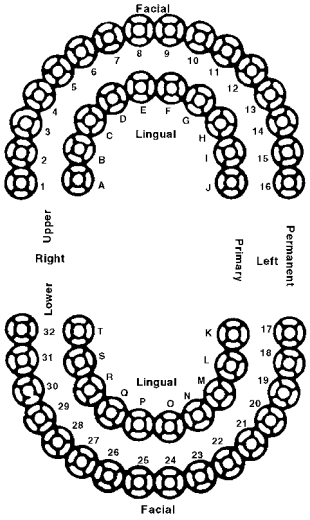
(WORK COMPLETED - PAYMENT REQUESTED)
THE TREATMENT LISTED BELOW WAS COMPLETED AND WAS NECESSARY IN MY JUDGMENT.

DENTIST SIGNATURE DATE

EXAMINATION AND TREATMENT RECORD

DATE FIRST VISIT (CURRENT SERIES) MO. DAY YEAR

IDENTIFY MISSING TEETH WITH "X"



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 MO.	DAY	YEAR	FEE	ADMIN. USE ONLY

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