AS CLAIMS ADMINISTRATOR P.O. Box 909786-60690 Chicago, IL 60690
TEL: (800) 618-2694 FAX: (312) 602-6280

DENTAL CARE CLAIM FORM

INSTRUCTIONS: Complete the applicable items in Part 1. Give the form to your Provider to complete Part 2.
Return the completed form to ALLIED BENEFIT SYSTEMS, INC.

PART 1: TO BE COMPLETED BY EMPLOYEE

1. CLAIM IS BEING MADE FOR:
   [ ] Employee [ ] Unmarried Child. If child is 19 or over, benefits continued as: [ ] Full time student, attending _____ School
   [ ] Spouse [ ] Other

2. PATIENT'S NAME: DATE OF BIRTH: / / SEX:

3. IS THIS CLAIM DUE TO AN ACCIDENT? IF YES, WHERE DID ACCIDENT OCCUR? DATE OF ACCIDENT: / /
   [ ] Yes [ ] No
   DESCRIBE ACCIDENT:

4. IS THIS CLAIM AS A RESULT OF A WORK RELATED ILLNESS OR INJURY? [ ] Yes [ ] No

5. ARE YOU (EMPLOYEE) MARRIED? [ ] Yes [ ] No
   IF "YES", IS YOUR SPOUSE EMPLOYED? [ ] Yes [ ] No
   IF "YES", PLEASE PROVIDE:

   NAME OF SPOUSE

   EMPLOYER OF SPOUSE

   ADDRESS OF EMPLOYER

   IF CLAIM IS FOR A DEPENDENT CHILD, IS YOUR CHILD EMPLOYED? [ ] Yes [ ] No
   IF "YES", PLEASE PROVIDE:

   NAME OF DEPENDENT

   EMPLOYER OF DEPENDENT

   ADDRESS OF EMPLOYER

6. IS THE PATIENT COVERED UNDER ANY OTHER PLAN PROVIDING HEALTH BENEFITS? [ ] Yes [ ] No
   IF "YES", PROVIDE THE NAME AND ADDRESS OF THE COMPANY OR INSURANCE CARRIER PROVIDING BENEFITS:

   NAME OF COMPANY OF INSURANCE CARRIER

   STREET NUMBER | CITY | STATE | ZIP

7. EMPLOYEE'S NAME (PLEASE PRINT) | SOCIAL SECURITY NUMBER | (Area) TELEPHONE NUMBER

   STREET NUMBER | CITY | STATE | ZIP

8. AUTHORIZATION TO RELEASE INFORMATION:
   I hereby certify that the foregoing statements are true and correct to the best of my knowledge. I also authorize any hospital, physician, or other persons who have attended me or examined me or any of my dependents, to disclose to Allied Benefit Systems, Inc. and/or my employer any and all information with respect to any illness or injury, medical history, consultation, diagnosis or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

   PATIENT'S SIGNATURE DATE
   (If other than Employee, omit if patient is a minor.)

   EMPLOYEE'S SIGNATURE DATE

9. ASSIGNMENT OF BENEFITS:
   I hereby authorize payment directly to the provider of medical services which are otherwise payable to me for services rendered. Payment will be made in accordance with the provisions of the benefit plan.

   EMPLOYEE'S SIGNATURE DATE

10. **Plumbers Local #93 Health and Welfare Fund** | **B04155** | **(815) 759-5900**
    NAME OF EMPLOYER | GROUP NO. | TELEPHONE NUMBER

    31855 North U.S. Highway 12 | **Volo** | **IL** | **60073**
    STREET NUMBER | CITY | STATE | ZIP