

# LOCALS 302 AND 612, INTERNATIONAL UNION OF OPERATING ENGINEERS, CONSTRUCTION INDUSTRY HEALTH AND SECURITY FUND

EMPLOYEE STATEMENT										
<input type="checkbox"/> <b>Check here if your address is new.</b>										
PART 1 - EMPLOYEE INFORMATION										
EMPLOYEE'S NAME - First			Initial		Last		<input type="checkbox"/> M <input type="checkbox"/> F		EMPLOYEE SOCIAL SECURITY NUMBER	
HOME ADDRESS		STREET			CITY		STATE		ZIP	PHONE
EMPLOYED BY								LOCAL NO.		
PATIENT'S NAME - First			Initial		Last		<input type="checkbox"/> M <input type="checkbox"/> F		PATIENT SOCIAL SEC. NO.	PATIENT BIRTH DATE
							Mo.	Day	Year	RELATION TO EMPLOYEE
										<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> 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?				
<input type="checkbox"/> MARRIED <input type="checkbox"/> LEGAL SEP. <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> ADOPTED CHILD <input type="checkbox"/> FOSTER CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> GUARDIANSHIP <input type="checkbox"/> OTHER (EXPLAIN) _____				<input type="checkbox"/> YES <input type="checkbox"/> NO    NAME OF SCHOOL _____ IF "NO", DOES CHILD HAVE A DEVELOPMENTAL DISABILITY OR PHYSICAL HANDICAP? <input type="checkbox"/> YES <input type="checkbox"/> NO				
NAME OF SPOUSE ( if not patient listed above)						SPOUSE BIRTHDATE		SPOUSE SOCIAL SECURITY NO.		
IS SPOUSE EMPLOYED?		NAME & ADDRESS SPOUSE'S EMPLOYER								
<input type="checkbox"/> YES <input type="checkbox"/> NO										
PART 2 - INSURANCE INFORMATION										
ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANOTHER GROUP INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO										
IF "YES", GIVE NAME AND ADDRESS OF OTHER CARRIER _____										
NAME OF SUBSCRIBER _____					SUBSCRIBER SOC. SEC. NO. _____					
OTHER GROUP PLAN COVERS: <input type="checkbox"/> PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILDREN    OTHER GROUP PLAN POLICY OR I.D.# _____										
OTHER GROUP PLAN INCLUDES: <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION										
ARE YOU OR YOUR DEPENDENTS COVERED UNDER MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> 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.										
<b>EMPLOYEE'S SIGNATURE X</b>								DATE    /    /		
PROCEDURE FOR FILING A CLAIM										
<b>INSTRUCTIONS TO THE EMPLOYEE:</b>										
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.										
<b>INSTRUCTIONS TO THE DENTIST:</b>										
1. <b>Predetermination of cost is required if proposed treatment is extensive.</b> 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 <b>employee must sign the bottom line on the reverse side of this form.</b>										
<b>Upon completion of treatment, return this form to:</b>										
<b>Op Engs Loc 302 &amp; 612</b> <b>H &amp; S Fund</b> <b>P.O. Box 34684</b> <b>Seattle, WA 98124-1684</b> Phone: (206) 441-7574 or 1-800-331-6158										
<b>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.</b>										

