DENTAL PLAN BENEFITS

I.B.U. NATIONAL HEALTH BENEFIT PLAN
PMB #116, 5331 S Macadam Ave., Suite 258
Portland, OR 7239
Portland Area (503) 224-0048 All Other Locations (800) 547-4457

PART 1: MUST BE COMPLETED BY EMPLOYEE

1. PATIENT'S NAME *(First name, middle initial, last name)*	2. PATIENT'S DATE OF BIRTH	3. EMPLOYEE'S NAME, ADDRESS AND PHONE NO.
FULL TIME STUDENT ☐YES ☐NO IF YES, WHERE		
4. PATIENT'S ADDRESS *(if different from employee)*	5. PATIENT'S SEX MALE ☐ FEMALE ☐	6. EMPLOYEE'S SOC. SEC. NO.
9. IS PATIENT ALSO COVERED BY ANOTHER GROUP HEALTH PLAN? ☐YES ☐NO *If Yes, List Plan Name, Employer and Address*	7. PATIENT'S RELATIONSHIP SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	8. EMPLOYER LOCATION
	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES ☐ NO ☐ B. AN ACCIDENT YES ☐ NO ☐	11. IF AN ACCIDENT ☐ A.M. date_____20___ and time_____ ☐ P.M. description (how & where)_____

12. AUTHORIZATION TO RELEASE INFORMATION

PATIENT OR PARENT RELEASE SIGN BELOW
I hereby authorize any insurance company, prepayment organization, employer, hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge.

X_____
PATIENT OR PARENT (IF MINOR) DATE

13. AUTHORIZATION TO PAY BENEFITS TO PROVIDERS

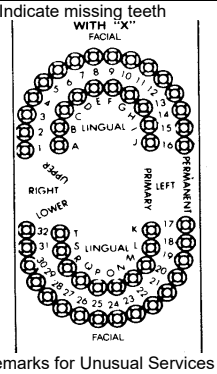
IF PAYMENT IS TO BE MADE TO PROVIDER SIGN BELOW
I hereby authorize payment of benefits directly to any providers of services, but not to exceed the usual, reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

X_____
EMPLOYEE DATE

PART 2: TO BE COMPLETED BY PHYSICIAN (OR ATTACH ITEMIZED BILL)

14. Dentist Name		Yes	No	If yes, Enter Brief Description & Dates
15. Mailing Address	Result Of Auto Accident			
16. Dentist (Soc. Sec or T.I.N)				
19. First visit date Current Series				(If no, Reason for Replacement) / 27. Date of Prior Placement
	Treatment for Orthodontics			28. If service already commenced Enter / Date Appliance Placed / Mos. Treatment Remaining?

Indicate missing teeth WITH "X"



30. Remarks for Unusual Services

Examination and Treatment Plan – LIST IN ORDER NO 1 THROUGH TOOTH NO 32 – USE CHARTING SYSTEM SHOWN			32 Date Service Performed MO DA YR	Procedure Number	Fee	For Administrative Use Only
Tooth # or Let.	Surface	Description of Service (Including X-Rays, Prophylaxis, Material Used Etc)				

I hereby certify that The Procedures As Indicated By Date Have Been Competed

Signed (Dentist)_____ Date _____

Total Fee Charged	
Max. Allowable	
Deductible	
Carrier %	
Carrier Pays	
Patient Pays	

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HOW TO REQUEST BENEFITS

1. CLAIM FORMS ARE AVAILABLE AT WWW.IBUBENEFITS.ORG AND YOUR PERSONNEL OFFICE

2. COMPLETE THE "PATIENT INFORMATION" (ITEMS 1 THROUGH 12) ON THE ABOVE FORM.

   If you wish your dental benefits paid directly to your provider sign item 13.

3. HAVE YOUR DENTIST COMPLETE THE "DENTIST OR SUPPLIER INFORMATION".

4. ATTACH THE COMPLETED "BENEFIT REQUEST FORM" TO THE BILLS AND MAIL THEM TO THE PLAN ADMINISTRATOR AT THE FOLLOWING ADDRESS BELOW.

5. A SEPARATE FORM MUST BE SUBMITTED FOR EACH FAMILY MEMBER FOR WHOM A CLAIM FOR BENEFITS IS BEING MADE.

WHERE TO FILE A CLAIM:

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TO CHECK YOUR ELIGIBILITY – CALL THE ADMINISTRATION OFFICE

In Portland Area (503) 224-0048

All Other Locations (800) 547-4457

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