DENTAL PLAN BENEFITS

WESTERN STATES HEALTH & WELFARE
TRUST FUND OF THE OPEIU
PMB #116, 5331 S Macadam Ave, Suite 258
Portland, OR 97239
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)_____ _____

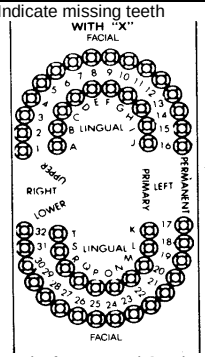
12. AUTHORIZATION TO RELEASE INFORMATION	13. AUTHORIZATION TO PAY BENEFITS TO PROVIDERS
PATIENT OR PARENT RELEASE SIGN BELOW I hereby authorize any insurance company, prepayment organization, employer, hospital or physician, to release all information with respect to myself or any of my dependents which 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	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			22. Is Treatment Result of Occupational Illness or injury?	Yes	No	If yes, Enter Brief Description & Dates
15. Mailing Address			23. Is Treatment Result Of Auto Accident			
City, State, Zip			24. Other Accident			
16. Dentist (Soc. Sec or T.I.N)	17. Dentist Lic. No.	18. Dentist Phone No.	25. Are any Services covered by another Plan?			

19. First visit date Current Series	20. Place of Treatment	21. Radiographs or Models Enclosed?	No	Yes	How Many?	26. If Prosthesis, Is this initial Placement		(If no, Reason for Replacement)	27. Date of Prior Placement
						27. Is this 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

Tooth # or Let.	Surface	Description of Service (Including X-Rays, Prophylaxis, Material Used Etc)	32 Date Service Performed MO DA YR	Procedure Number	Fee	For Administrative Use Only

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

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

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

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

4. 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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CHECK YOUR ELIGIBILITY – CALL THE ADMINISTRATION OFFICE

In Portland Area (503) 224-0048

All Other Locations 1-800-547-4457