

# DENTAL PLAN BENEFITS

ALASKA SEAFOOD PROCESSORS PLAN  
 SPONSORED BY INLANDBOATMEN'S UNION  
 PMB #116 5331 SW Macadam Avenue Suite 258  
 Portland, OR 97239  
 Portland Area: (503) 224-0048  
 All Other Locations: (800) 547-4457

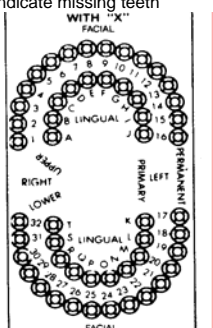
## PART 1: MUST BE COMPLETED BY EMPLOYEE

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 <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHERE					
4. PATIENT'S ADDRESS (if different from employee)		5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		6. EMPLOYEE'S SOC. SEC. NO.	
9. IS PATIENT ALSO COVERED BY ANOTHER GROUP HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, List Plan Name, Employer and Address		7. PATIENT'S RELATIONSHIP SELF SPOUSE CHILD OTHER <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		8. EMPLOYER LOCATION	
		10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>		11. IF AN ACCIDENT <input type="checkbox"/> A.M. date _____ 20____ and time _____ <input type="checkbox"/> P.M. description (how & where) _____ _____	

## 12. AUTHORIZATION TO RELEASE INFORMATION 13. AUTHORIZATION TO PAY BENEFITS TO PROVIDERS

<b>PATIENT OR PARENT RELEASE SIGN BELOW</b> 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		<b>IF PAYMENT IS TO BE MADE TO PROVIDER SIGN BELOW</b> 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	
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## 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" FACIAL 		Examination and Treatment Plan - LIST IN ORDER NO 1 THROUGH TOOTH NO 32 - USE CHARTING SYSTEM SHOWN (Including X-Rays, Prophylaxis, Material Used Etc)				32 Date Service Performed MO DA YR		Procedure Number	Fee	For Administrative Use Only
30. Remarks for Unusual Services		Tooth # or Let.		Surface		Description of Service				

I hereby certify that The Procedures As Indicated By Date Have Been Completed							Total Fee Charged	
Signed (Dentist) _____ Date _____							Max. Allowable	
							Deductible	
							Carrier %	
							Carrier Pays	
							Patient Pays	

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## HOW TO REQUEST BENEFITS

1. CLAIM FORMS ARE AVAILABLE AT [WWW.IBU.AIBPA.COM](http://WWW.IBU.AIBPA.COM) 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:

ALASKA SEAFOOD PROCESSORS PLAN - IBU  
PMB #116 5331 SW Macadam Avenue Suite 258  
Portland, OR 97239  
Portland Area (503) 224-0048 All Other Locations (800)547-4457

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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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