Connecticut Pipe Trades Health Fund
1155 Silas Deane Highway
Wethersfield, CT 06109-4318
860-571-9191

Group #10777

STATEMENT OF CLAIM
FOR DENTAL EXPENSE BENEFITS

(Please Read Instructions on Reverse Side Before Completing This Form)

☐ DENTIST'S PRE-TREATMENT ESTIMATE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

PATIENT SECTION

1. PATIENT NAME (FIRST MIDDLE LAST)	2. RELATIONSHIP TO MEMBER	3. SEX	4. PATIENT BIRTHDATE	5. IF FULL-TIME STUDENT
	☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER _____	MALE / FEMALE	MONTH / DAY / YEAR	SCHOOL / CITY

6. MEMBER'S NAME AND MAILING ADDRESS	7. MEMBER'S SOCIAL SECURITY NUMBER	8. MEMBER'S BIRTHDATE (MONTH / DAY / YEAR)	9. POLICYHOLDER NAME AND ADDRESS	10. GROUP NUMBER
			Connecticut Pipetrades Health Fund Local No. 777 1155 Silas Deane Hwy. Wethersfield, CT 06109	

11. IS PATIENT COVERED BY ANOTHER PLAN OF BENEFITS?	12-a. NAME AND ADDRESS OF CARRIER(S)	12-b. GROUP NO(S).	13. NAME AND ADDRESS OF EMPLOYER
DENTAL _____ MEDICAL _____			

14-a. EMPLOYEE/SUBSCRIBER NAME (IF DIFFERENT THAN PATIENT'S)	14-b. EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NUMBER	14-c. EMPLOYEE/SUBSCRIBER BIRTHDATE (MONTH / DAY / YEAR)	15. RELATIONSHIP TO PATIENT
			☐ SELF ☐ PARENT ☐ SPOUSE ☐ OTHER _____

15a. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. **I KNOW IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT.**

SIGNED (PATIENT OR PARENT IF MINOR) _____ DATE _____

15b. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED (INSURED PERSON) _____ DATE _____

DENTIST SECTION

16. DENTIST NAME	17. MAILING ADDRESS	CITY, STATE, ZIP

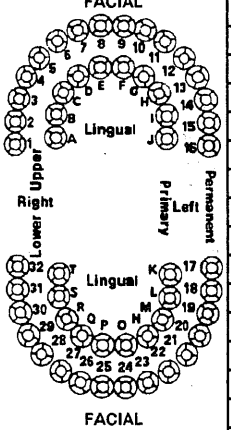
18. DENTIST SOC. SEC. OR T.I.N.	19. DENTIST LICENSE NO.	20. DENTIST PHONE NO.

21. FIRST VISIT DATE CURRENT SERIES	22. PLACE OF TREATMENT (OFFICE / HOSP. / ECF / OTHER)	23. RADIOGRAPHS OR MODELS ENCLOSED? (NO / YES / HOW MANY?)	30. IS TREATMENT FOR ORTHODONTICS?	IF SERVICES ALREADY COMMENCED ENTER	DATE APPLIANCES PLACED	MOS. TREATMENT REMAINING

24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
26. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			

28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	(IF NO, REASON FOR REPLACEMENT)	29. DATE OF PRIOR PLACEMENT

IDENTIFY MISSING TEETH WITH "X"



32. REMARKS FOR UNUSUAL SERVICES

31. EXAMINATION AND TREATMENT PLAN-LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32-USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED (MO / DAY / YEAR)	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED. I KNOW IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT.

SIGNED (DENTIST) _____ DATE _____

TOTAL FEE CHARGED	
MAX. ALLOWABLE	
DEDUCTIBLE	
CARRIER %	
CARRIER PAYS	
PATIENT PAYS	

PLEASE REVIEW BEFORE SUBMITTING CLAIM

Information for Employee

1. Complete items 1 through 15b in full to assure positive identification and prompt payment. Please print or type.

2. You must sign the claim form in the area designated item 15b immediately above the Dentist's Section. You can arrange to have payment made directly to the dentist by checking the "Yes" box in item 15b where you sign the claim form. If you wish to have benefits paid directly to you, check the "No" box. In either case, a statement will be sent to you showing the benefits payable.

3. The patient (or parent, if patient is minor) must sign the form in item 15a.

4. If total charges for the planned course of treatment will be less than $100, **the completed claim form should be returned to the Policyholder after the treatment is completed.**

5. If total charges for the planned course of treatment can reasonably be expected to be $100 or more, the completed form should be returned to the Policyholder for submission to Employee Benefit Plan Administrators,Inc. prior to the commencement of the course of treatment, for a pre-determination of benefits. Employee Benefit Plan Administrators,Inc. will notify you and your dentist of the benefits payable.

Dental coverage is subject to specific limitations and exclusions. Please refer to your benefits booklet for a description of covered services, benefits payable, and limitations and exclusions.

Information for Attending Dentist

1. If total charges for a course of treatment are less than $100, check the box noted "Statement of Actual Services" (top right corner of the claim form) and complete items 16 through 31 when treatment has been completed. **The claim form should be returned to the Member for forwarding to the Policyholder.**

2. If total charges for a course of treatment can reasonably be expected to be $100 or more, check the box noted "Pre-Treatment Estimate" (top right corner of the claim form) and complete items 16 through 31. For some procedures, supplementary pre-treatment information may also be required. The completed claim form, together with any required supplementary information, should be returned to the Policyholder prior to the commencement of the course of treatment.

   Employee Benefit Plan Administrators,Inc. will review the claim (and any supplementary information submitted) and notify you and your patient of the benefits payable.

   You and your patient are free to pursue any treatment plan mutually agreed upon. Pre-determination of benefits is only intended to avoid any misunderstanding among the patient, the dentist, and the provider of benefits, concerning the benefits payable under the terms of the coverage. Pre-determination of benefits is not required for oral examinations, cleanings, fluoride applications, dental x-rays, or emergency treatment.

3. Generally, x-rays will not be required pre-operatively where restorative dentistry involving only standard filling material is utilized.

   Diagnostic x-rays should be submitted only in connection with prosthetics, fixed bridgework, or cast restorations. Occasionally, we may request x-rays that relate to other dental services.

4. If the Member has so authorized, benefit payment will be made directly to you.