

DENTAL PLAN BENEFITS

HARRISON ELECTRICAL WORKERS TRUST FUND

1220 S.W. Morrison, Suite 300

Portland, OR 97205-2222

Portland Area: (503) 224-0048 All Other Locations: (800) 547-4457

PART 1: MUST BE COMPLETED BY EMPLOYEE

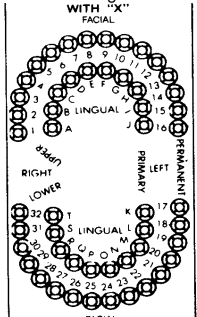
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|---|--|--|--|--|--|
| 1. PATIENT'S NAME (First name, middle initial, last name) | | 2. PATIENT'S DATE OF BIRTH | | 3. EMPLOYEE'S NAME, ADDRESS AND PHONE NO. | |
| FULL TIME STUDENT YES NO IF YES, WHERE | | | | | |
| 4. PATIENT'S ADDRESS (if different 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 _____ DATE _____ PATIENT OR PARENT (IF MINOR) | | 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 _____ DATE _____ EMPLOYEE | |
|---|--|--|--|

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"  | Examination and Treatment Plan – LIST IN ORDER NO 1 THROUGH TOOTH NO 32 – USE CHARTING SYSTEM SHOWN | | | | 32 Date Service Performed | | Procedure Number | Fee | For Administrative Use Only |
| | Tooth # or Let. | Surface | Description of Service (Including X-Rays, Prophylaxis, Material Used Etc) | | MO | DA | | | |
| 30. Remarks for Unusual Services | | | | | | | | | |

| | | | | | | | | |
|---|--|--|--|--|--|--|-------------------|--|
| 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. 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