PRESSMEN WELFARE FUND

7130 Columbia Gateway Drive, Suite A
Columbia, Maryland 21046
PHONE (410) 872-9500

DENTAL CARE CLAIM FORM

Type or Print | **This portion to be completed by the employee**

1. Social Security Number

2. Employee's Name (Last, First and Middle)

3. Employee's Address (Street, City, State and Zip Code)

4. Patient's Name (Last, First and Middle)

5. Patient's Birthdate — Mo | Day | Year

6. Patient's Relationship to Subscriber (Check Appropriate Box)
   Male ☐ Self (1) ☐ Spouse (3) ☐ Son (5)
   Female ☐ Self (2) ☐ Spouse (4) ☐ Daughter (6)

7. Employer

8. Is the patient covered under another Dental Benefits Plan? ☐ Yes ☐ No If yes: carrier name
   policy holder _____ policy number _____ effective date _____ Individual ☐ Family ☐

9. Is treatment a result of injury? ☐ Yes ☐ No If yes date of injury _____ If yes did injury occur on the job? ☐ Yes ☐ No **Worker's Compensation**

10. I certify that the above information is correct and apply for benefits under my dental coverage with the plan, I authorize any dentist or physican in possession of information concerning the patient to furnish such information to the Plan upon request.
    Signature of Employee _____ Date _____

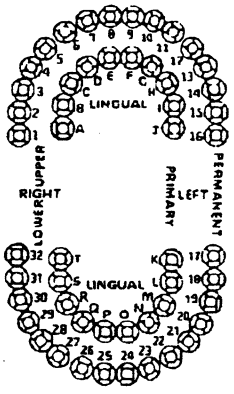
11. Assignment of Benefits ☐ Yes ☐ No
    If answer is yes sign again
    _____ Signature of Employee

Part II - Attending Dentist's Statement - Please Print

Name of Dentist (First, Last)	Dentist's Telephone Number	Name of Patient (Last, First, M.I.)	Is dentist related to patient by blood or marriage? ☐ Yes ☐ No Relationship _____
...ist's Office Location (No., Street, City, State, ZIP Code)		**Orthodontic Treatment** ➤ Date Appliance Inserted	Expected Treatment Duration: _____ Months / Class of Malocclusion ☐ I ☐ II ☐ III
Dentist's Tax I.D.	New location? ☐ Yes ☐ No More than 1 office? ☐ Yes ☐ No	Is treatment the result of an accident? ☐ Yes ☐ No If Yes: ☐ Occupational ☐ Auto ☐ Other	For crown, bridge or other prosthesis is this initial placement? ☐ Yes ☐ No / If not, date of prior placement. Mo. _____ Year _____
Remarks		Prior partial? ☐ Yes ☐ No / If No, Date of Extractions / Teeth Involved in Prior Prosthesis	
		Final Prep Date _____ Impression Date _____ Seat Date _____	

IDENTIFY MISSING TEETH WITH AN "X" FOR ALL SUBMISSIONS

FACIAL



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Examination and Treatment Plan- List in order from tooth No. 1-32 (Use Chart System Shown)

Tooth Number or Letter	Surface	Description of Service (including X-rays, prophylaxis, materials, etc.) Line No.	Date Service Performed MM DD YY	Procedure Number	Fee	For Administrative Use Only

Radiographs or Model Enclosed ☐ Yes ☐ No

Dentist's Signature _____ Date _____ ☐ Check if X-Rays are to be returned to Dentist

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

PREDETERMINATION OF BENEFITS DOES NOT GUARANTEE PAYMENT - Recommended for charges of $200.00 or more. Predetermination of your claim advises you in advance of the amount of benefits payable if described procedures are performed during a period of patient's eligibility. Benefits payable are subject to COB and other policy provisions.