Dental Claim Form



Signed (Dentist)





PARTICIPATING DENTIST CLAIM FORM

Insured and/or Administered by Connecticut General Life Insurance CIGNA HealthCare



UFT WELFARE FUND C/O CONNECTICUT GENERAL LIFE INSURANCE COMPANY P.O. BOX 182531 CHATTANOOGA, TN 37422-7531 1-800-577-0576

CHARGED

LAMINATE VENEERS, BRIDGES PERIODONTAL SURGERY OR V WILL EXCEED \$500 IN A 90 DAY	WHEN EXPEN	PLEA FOR SES PRE-	ASE SUBI NON-RO - ANDPO	CLAIM MIT PRE-TREATMENT DUTINE EXTRACTIONS ST-TREATMENT X-RA' L THERAPY	S AND	· 🗆	res - Spouse/D herefore eligibl	IBER RETIRE omestic Partner is le for Special C.O.E tic Partner Social So	a UFT Med 3.
MEMBER INFORMATION- S	See Instruc	tions on i	reverse	e side					
Member Name (Please Print)	JCC 111011 U.S.	tions and	10.0.	Birth Date		Sex	Social Security	y Number	
Home Address	City			State	Zip C	Code	Teleph (one#	
School or Bureau Name and Address of Other Compar		School Teler () Providing De	-	efits under which you ar		Yes	G.H.I. medical co	overage?	
PATIENT INFORMATION									
Patient Name (Please Print)		Birth Da	ate	Relationship to Memb	per Fu	Il Time Coll	ege Student	If yes, what school	?
SPOUSE/DOMESTIC PART		RMATION	- (Requ					er or Depende	
Spouse/Domestic Partner Name (Ple	,			Spouse/Domestic Pa	1				Security #
Is spouse/domestic partner covered	by another Den	tal Benefits P	Plan other	than UFTWF? Ye	s 🗌 I	No If y	es, specify belov	w.	
Name and Address of Other Compar	ny/Organization	Providing De	ental Ben	efits			Company/Orga	anization Telephone	#
AUTHORIZATION (Authoriz	zation to re	lease info	ormatio	onmust be signed	or pa	yment v	rill not be m	ade)	
To Release Information: I have revi		•	-				-	aim.	
Signed (Patient or Parent if Minor) To Assign Benefits: I hereby author						Da		· '1 Enoncially	neibl
	y this assignme	ent. This auth		is invalid unless the TA		the provide	r is given below.		responsible
Signed (Member) DENTIST INFORMATION - (S Dentist Name (Please Print)			norization	is invalid unless the TA	X ID # ol	the provide	te:		
Signed (Member) DENTIST INFORMATION- (S			norization	is invalid unless the TA	X ID # ol	the provide Da	r is given below te:		
Signed (Member) DENTIST INFORMATION- (S Dentist Name (Please Print)	See instruc		norization	is invalid unless the TAX ck regarding the I License #	X ID # ol	the provide Da	r is given below te: Taxpayer ID #		
Signed (Member) DENTIST INFORMATION- (S Dentist Name (Please Print) Street Address If prosthesis, is this the initial placem Yes \(\square\) No If no, the reason for	City nent? replacement Are radiogu	ctions on the control of the control	the bac	ck regarding the I	need f	the provide Da	te: Taxpayer ID # Telephone #	Date of Prior Place	ement
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