

Complete and Return To:  
**PLUMBERS AND STEAMFITTERS LOCAL 43 HEALTH AND WELFARE FUND**

2187 Northlake Parkway  
 Suite 106, Building 9  
 Tucker, Georgia 30084-4149



**STATEMENT OF CLAIM**

TO BE COMPLETED BY EMPLOYEE

1. Employee's Name		Social Security Number	Local Union Number
2. Address		City	State Zip Code
3. This claim is for: Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>		Name <input type="checkbox"/>	Date Of Birth <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/>
4. If an accident was involved, describe briefly below:		Did accident happen while at work? Date of accident _____ AM _____ PM	
5. Are You or any Covered Family Member covered under any other Group or Group-type Plan for Medical or Dental Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete items 6 and 7			
6. Name of Family Member		Relationship	Employer's Name and Address
7. Name and Address of Other Insurance Company			Other Policy Number
I hereby agree to reimburse the Plumbers and Steamfitters Health and Welfare Fund to the extent of any overpayment which is in excess of the amounts payable under this group plan and 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 certify that the information by me in support of this claim is true and correct to the best of my knowledge.			
Date _____		Employee's Signature _____	
I authorize payment directly to the dentist completing this form of the Group Dental Benefits otherwise payable to me but not to exceed the charges stated. I understand I am financially responsible for charges not covered by this authorization.			
Date _____		Employee's Signature _____	

TO BE COMPLETED BY ATTENDING DENTIST

Dentist's Name		S.S. or TIN NO. (required by law)	If prosthesis, is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Dentist's Mailing Address (Street)		Telephone Number	If 'No', reason for replacement				
City	State	Zip Code	Specialty	Date of initial placement, existing prosthesis			
If treatment is for Orthodontic purposes, indicate date active treatment started:		Date first appliance inserted:	Estimated total active treatment period (months)	Total fee for active treatment incl. appliance: \$			
Indicate missing teeth with an "x" 	Tooth No. of Letter	Surfaces	Description of Service (including x-rays, prophylaxis materials used, etc.)	Date Service Completed (Mo., Day, Yr.)	ADA Procedure Number	Fee by Procedure	For Admin. Use only
Remarks:					Total fee charged \$		
Note: Benefits will be paid directly to the Insured unless indicated otherwise in Section 8. By my signature below, I certify that the above statement and all other information provided by me pertaining to this claim are correct.							
Dentist's Signature X			Date				

