MILLWORKERS HEALTH & WELFARE PLAN (UNIFOR)

45 McINTOSH DRIVE, MARKHAM, ON L3R 8C7 Phone: 1-800-263-3564 Fax: 905-946-2535 email: guestions@millworkersuniforbenefits.org



UNIQUE NO. SPEC. PATIENT'S OFFICE ACCOUNT NO.																								
P	ARI	1 -	- [DE	NTI	ST					UNIQ	UNIQUE NO. SPEC.						PATIENT	r's of	FFICE ACO	OUNT NO.	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO THEM.		
Р	LAS	T NAME							GIVEN NAME	D											THEM.			
A T	ADD	RESS								APT.	E N													
E N	7,00									7 1.	T I S PHONE NO. T													
T	CITY	,				PF	ROV.		POSTAL	CODE												SIGNATURE OF SUBSCRIBER		
	R DENTI		NLY -	- FOF	ADDI	ITIONAL	INFORM	MATION, DIAGNOSI	S, PRO	CEDUR	ES, OR SI	PECIAL									ES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED			
	VOIDET	WION.															THI AC RE MY	MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOI THE ENTIRE TREATMENT. I ACKNOWLEDGE THAT THE TOTAL FEE OF \$ ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED. I AUTHORIZE TH RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO THE PLAN, MY INSURER, ANI MY POLICYHOLDER. THE INFORMATION RELEASED THROUGH THIS AUTHORIZATION IS TO BI USED FOR CLAIMS ADJUDICATION PURPOSES AND STATISTICAL ANALYSIS. SIGNATURE OF PATIENT (PARENT/GUARDIAN						
													OFFICE VERIFICATION/DENTIST'S SIGNATURE											
	OF SE		Г				Τ.,	NTL.																
YR.	MO. DAY			PROCEDURE CODE			TOOTH CODE		TOOTH SURFACES	DENTI FE				LABORAT CHAR					TOTAL CHARGES			FOR CARRIER USE		
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			\vdash										+								IN\ MA	IVOLVING FEES OF \$600.00 OR MORE, HIS/HER TREATMENT PLAN AY BE SUBMITTED TO THE PLAN IN ADVANCE FOR		
													1								,	REDETERMINATION OF BENEFITS. THE PLAN WILL INFORM YOU BEFORE YOU UNDETTAKE TREATMENT, OF THE AMOUNT LLOWED BY THE PLAN.		
			\vdash		+	+	+				+		+				\vdash		+					
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE. TOTAL FEE SUBMITTED																								
II	INSTRUCTIONS FOR CLAIM SUBMISSION																							
	1. HAVE THE ATTENDING DENTIST COMPLETE PART 1. 3. ALL PARTS OF THIS FORM MUST BE COMPLETED IN FULL. IF NEEDED INFORMATION IS MISSING, THE FORM MAY BE RETURNED TO YOU. 2. COMPLETE PARTS 2 AND 3 BELOW ON EACH FORM SENT IN. 4. ALL CORRESPONDENCE, CLAIM FORMS, ETC MAIL TO: THE PLAN ADMINISTRATION OFFICE																							
P	ART	2 -	– I	ИE	MB	ER	}																	
1.	1. CONTROL NO./PLAN NO BRANCH NO ADDRESS OF MEMBER																							
	EMPLO	OYER _												_	N	ИЕМВЕ	R'S D	ATE OF	BIRT	TH: YEAR		MONTH DAY		
2.	2. NAME OF MEMBER MEMBER'S SOCIAL INSURANCE NUMBER/IDENTITY NUMBER																							
P	ART	3 -	_ [PAT		NT	INF	ORM	IATION															
1.	PATIEN	NT: REL	.ATIO	NSHI	Р ТО І	ИЕМВ	ER											5. A) I	S AN'	Y TREATME		RED AS THE RESULT OF AN ACCIDENT?		
		DAT	E OF	BIRT	H: Y	ÆAR .			MONTH			DAY_						☐ YES NO ☐ GIVE DATE AND DETAILS						
2.	IF CLA	IM IS FO	OR D	EPEN	IDENT	CHIL	D, IS TH	IAT CHILI	D									B) I	S CL	AIM BEING	MADE FOR \	WORKERS' COMPENSATION BENEFITS? ☐ YES NO ☐		
														по [6. IF THE TREATMENT INVOLVES THE PLACEMENT OF A BRIDGE, DENTURE OR CROWN: A) IS THIS THE INITIAL PLACEMENT? LOWER VES NO VES N						
A FULL TIME STUDENT? YES NO EMPLOYED? YES NO UPPER YES NO LOWER YES N B) IF "NO" GIVE THE DATE OF PRIOR PLACEMENT AND THE REASON FOR F 3. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER PLAN OF INSURANCE OR DENTAL SERVICES: YES NO IF "YES," PROVIDE:																								
		POL	ICY I	NUME	BER: _											_		DATE OF EXTRACTIONS Privacy Statement: I authorize the Millworkers Health & Welfare and Pension Plans (together called "the Plans"), their administrator Employee Benefit Plan Services Limited, and providers working with the Plans or administrator to collect, maintain, use and disclose my personal information that is necessary for the						
	SPOUSE'S NAME:													administration of the Plans. Personal information will be protected pursuant to the applicable legislation. The Plans may collect, maintain, use and disclose my personal information with relevant persons or organizations (employers, health benefit managers, health professionals, institutions, insurers, investigative agencies, legal										
4.	IS ANY									YES								counsel, other plans or unions, pharmacies, regulators, re-insurers) in order to manage the Plans and entitlement to the benefits of the Plans, and may include information such as financial, health or benefits related information. Questions related to the Privacy Statement should be directed to the Privacy Officer						
4. IS ANY OF THE ABOVE WORK FOR ORTHODONTIC PURPOSES? LI YES NO LI														MEMBER'S SIGNATURE: DATE: YEAR MONTH DAY										
																			. Lni					