UFCW LOCAL 247 BENEFIT TRUST FUND

FORM – F2

PART 1 DENTIST

UNIQUE NO. | SPEC. | PATIENT'S OFFICE ACCOUNT NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

SIGNATURE OF SUBSCRIBER

PATIENT

LAST NAME GIVEN NAME

ADDRESS APT.

CITY PROV. POSTAL CODE

DENTIST

PHONE NO.

FOR DENTIST'S USE ONLY. FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.

DUPLICATE FORM ☐

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT.

I ACKNOWLEDGE THAT THE TOTAL FEE OF $ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED.

I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY PLAN ADMINISTRATOR.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

THIS IS AN ACCURATE STATEMENT OF SEVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.

TOTAL FEE SUBMITTED $

INSTRUCTIONS

IF CHARGES WILL BE $300 OR MORE, YOUR CLAIM SHOULD BE SUBMITTED FOR PREDETERMINATION OF BENEFITS.

ROUTINE ORAL EXAMINATIONS, SCALING AND CLEANING, FLUORIDE TREATMENTS, X-RAYS, BASIC RESTORATIONS AND EMERGENCY TREATMENT MAY BE PERFORMED BY YOUR DENTIST PRIOR TO SUBMITTING YOUR CLAIM FOR PREDETERMINATION OF BENEFITS.

X-RAYS MAY BE REQUESTED TO BE SUBMITTED FOR CROWNS OR BRIDGEWORK. X-RAYS WILL BE RETURNED PROMPTLY TO YOUR DENTIST.

MAIL ALL CLAIM FORMS, PREDETERMINATIONS AND X-RAYS TO:

UFCW LOCAL 247 BENEFIT TRUST FUND
318 - 2099 LOUGHEED HWY.
PORT COQUITLAM, BC V3B 1A8
TEL: (604) 945-7607

PART 2 MEMBER'S STATEMENT (Complete this part before taking the form to your dentist's office.)

1. PATIENT: RELATIONSHIP TO MEMBER _____ DATE OF BIRTH _____

IF CHILD AGE 21 OR OVER INDICATE STUDENT ☐ HANDICAPPED ☐

2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE, GOVT. AGENCY OR DENTAL PLAN? ☐ NO ☐ YES

POLICY NUMBER _____

NAME OF INSURANCE AGENCY _____

IF CLAIM IS FOR A DEPENDENT CHILD PLEASE INDICATE SPOUSE'S DATE OF BIRTH _____

3. IS ANY TREATMENT REQUIRED AS A RESULT OF AN ACCIDENT? ☐ NO ☐ YES

GIVE DATE AND DETAILS _____

4. IS ANY TREATMENT FOR ORTHODONTIC PURPOSES? ☐ NO ☐ YES

5. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? ☐ NO ☐ YES

GIVE DATE OR PRIOR PLACEMENT AND REASON FOR REPLACEMENT. _____

6. IS TREATMENT RESULT OF AN OCCUPATIONAL ILLNESS OR INJURY, OR OTHERWISE RELATED TO EMPLOYMENT? ☐ NO ☐ YES

7. INITIAL CLAIM? ☐ SUBSEQUENT? ☐

8. MEMBER'S IDENTITY NUMBER / (SOCIAL INSURANCE #) ☐☐☐ – ☐☐☐ – ☐☐☐

9. DATE OF BIRTH _____

10. COMPANY NAME _____

11. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO U.F.C.W. LOCAL 247 BENEFIT TRUST FUND OR ITS AUTHORIZED REPRESENTATIVE OR CONSULTANT FOR PURPOSES OF SETTLEMENT OF THIS CLAIM

SHOULD THE ABOVE MEMBER IDENTIFICATION NUMBER REPRESENT MY SOCIAL INSURANCE NUMBER, I HEREBY AUTHORIZE U.F.C.W. LOCAL 247 BENEFIT TRUST FUND OR ITS AUTHORIZED REPRESENTATIVE TO USE MY SOCIAL INSURANCE NUMBER FOR PURPOSES OF ADMINISTRATION OF MY GROUP BENEFIT PLAN. I UNDERSTAND THAT MY SOCIAL INSURANCE NUMBER WILL BE KEPT IN STRICTEST CONFIDENCE AND WILL ONLY BE USED THE THE PURPOSES HEREIN.

MEMBER'S NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

DATE _____

SIGNATURE _____

PART 3 ADMINISTRATION

COVERED MEMBER'S EFFECTIVE DATE

DAY	MONTH	YEAR

PART TIME ☐ FULL TIME ☐

IN BENEFIT ☐ YES ☐ NO

YEAR	1 JAN	2 FEB	3 MAR	4 APR	5 MAY	6 JUN	7 JUL	8 AUG	9 SEPT	10 OCT	11 NOV	12 DEC

SIGNATURE OF AUTHORIZED OFFICIAL

DATE: _____

POSSESSION OF THIS CLAIM FORM DOES NOT CONSTITUTE ELIGIBILITY FOR BENEFITS

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

2/07

Please see reverse side for certification and consent, which must be signed.

CERTIFICATION AND CONSENT

I understand that it is an offence to make a false or misleading statement regarding the personal and claims information provided herein and declare that the information is true, correct and complete.

I certify that the charges for the dental services, identified by my dentist on the reverse side of this form, were incurred by me, or on account of one of my eligible dependents.

I authorize the use of my Social Insurance Number as an additional verification of my identity in the administration of my benefit entitlements. I understand that my Social Insurance Number will be kept in strictest confidence and will only be used for the specified purpose.

I understand that personal information about me and that of my eligible dependents as provided herein, as well as other personal information currently held or to be collected in the future, is required to: communicate with me; compute my benefits and those of my eligible dependents; satisfy any reporting requirements of the provincial and federal governments; comply with civil and criminal law; estimate future operating costs; assess Plan performance; accommodate audits of the Plan; and, if applicable, transfer data to a new replacement plan.

I hereby authorize the Board Of Trustees and the service agencies they employ to collect, record, use, disclose and, if applicable, destroy my personal information and that of my dependents who are under 21 years of age. I understand that all personal information will be kept confidential and secure, and that it will only be used for the purposes identified herein. Also, I understand that I may review the information, referenced herein, for myself or my dependents, who are under 21 years of age, to ensure that it is up-to-date, and that I may withhold or revoke my consent for its use, at any time. However, I realize that if I withhold or revoke my consent for its use, thereby limiting or restricting the ability to determine coverage and benefit entitlements, my participation in the Plan may be impaired or cancelled.

If I, or my dependents under 21 years of age, have coverage through another plan, I hereby authorize the Trustees to disclose personal information about me and my dependents in order to determine eligibility for coverage in the settlement of claims.

A photocopy of this authorization will be as valid as the original.

_____ _____

Signature of Plan Member Date

If an expense has been incurred by your eligible spouse, and is attached to this claim, please have your spouse sign the following.

I hereby consent to the collection, recording, use, disclosure and, if applicable, destruction of my personal information in the same manner as described above.

_____ _____

Signature of Spouse Date

If an expense has been incurred by an eligible dependent child age 21 or older, and is attached to this claim, please have your child sign the following.

I hereby consent to the collection, recording, use, disclosure and, if applicable, destruction of my personal information in the same manner as described above.

_____ _____

Signature of Dependent Child Age 21 or Over Date

_____ _____

Signature of Dependent Child Age 21 or Over Date