IUOE Local 132 Health and Welfare Fund
P.O. Box 2626 Huntington, West Virginia 25726-2626
(304) 525-0482 or 1-800-642-3525 www.iuoe132.org

DENTAL / VISION CARE BENEFIT CLAIM FORM

This form is to be completed by the Participant. One Claim Form per person is required unless additional information is requested by the Fund Office. Be sure all Questions are answered. Unanswered Questions will delay benefit consideration until the information is received.

If while covered, you or an eligible dependent incurs expenses for dental or vision care services which are not covered under the Major Medical Benefit, such expenses will be reimbursed at 100%. The maximum combined benefit for such dental and vision care expenses that will be paid in a calendar year on behalf of any covered individual is $500.

The program is intended to be a reimbursement arrangement where you pay the bill from the dentist or vision care provider and submit a receipt to the Fund Office for reimbursement. However, if you and the dentist or vision care provider can reach an agreement where they will accept payment from the Fund, with you responsible for any difference, you can instruct the dentist or vision care provider to submit the bill directly to the Fund Office and the Fund's check will be made payable to them.

Participant Information

Name: ____________________ ID number or SSN: ____________________

Address: ____________________ Home Phone: ____________________

____________________ Other Phone: ____________________

Name of Claimant and Relation to Participant

Patient Name: ____________________ ID number or Dependent SSN: ____________________

Relationship: ____________________

Claim Information

Provider Name: ____________________ Date of Service: ____________________

Provider Address: ____________________ Amount Paid: ____________________

____________________ **MUST ATTACH COPY OF RECEIPT(S)**

I hereby declare the information I have provided is true and correct. I understand that a false statement may disqualify me from benefits and that the Fund has the right to recovery from any Participant, any payments made as a result of misrepresentation, mistake or error, irrespective of the party causing such mistake or error.

I authorize release to or by the IUOE Local 132 Health and Welfare Fund of any medical or insurance information required to process any claims submitted on my behalf. A photocopy of this document may be honored.

I understand it is my responsibility to notify the Fund Office immediately should my spouse or dependent child(ren) become eligible with another insurance carrier or Plan.

➔ ____________________ ➔ ____________________

Participant's Signature Date Signed