

**AUTOMOTIVE, PETROLEUM & ALLIED INDUSTRIES EMPLOYEES WELFARE FUND LOCAL 618**  
 ROOM 232 • 300 SOUTH GRAND BLVD. • ST. LOUIS, MISSOURI 63103

INSTRUCTIONS: This form is to be completed by the member and the doctor. Complete member's section fully. Be sure to sign member's signature section and to show your Social Security No. Remember to attach itemized bills.

**RETURN COMPLETED  
FORM TO:**

**TEAMSTERS LOCAL 618  
HEALTH & WELFARE OFFICE  
ROOM 226, 300 SOUTH GRAND BLVD.  
ST. LOUIS, MISSOURI 63103**

**DENTAL FORM**

**MEMBER COMPLETES AND SIGNS THIS SECTION**

Name of Member _____		Date of Birth _____
Soc. Security No. _____	Occupation _____	Local No. _____
Home Address _____		PHONE NO. _____
Employer's Name and Address _____		
<b>MARITAL STATUS</b> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/>	<b>NAME OF SPOUSE</b>	<b>SOCIAL SECURITY NUMBER OF SPOUSE</b>
<b>IS SPOUSE EMPLOYED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>IF YES, GIVE NAME AND ADDRESS OF EMPLOYER</b>	<b>Are you or your spouse covered under health insurance for the aged under Social Security (Medicare)?</b> SELF: <input type="checkbox"/> YES <input type="checkbox"/> NO SPOUSE: <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>ARE SURGICAL OR DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER EMPLOYER, UNION, STUDENT, ASSOCIATION GROUP PLAN, OR GOVERNMENTAL PROGRAM APPLICABLE TO THIS CLAIM?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, INSERT NAME AND ADDRESS OF OTHER GROUP POLICY HOLDER AND INSURANCE COMPANY.		
<b>COMPANY OR INDIVIDUAL GROUP POLICY HOLDER</b>		<b>POLICY NUMBER</b>
<b>ADDRESS OF GROUP POLICY HOLDER</b>		<b>FOR BLUE CROSS/B. SHIELD GRP. NO. CERT. NO.</b>
<b>NAME OF INSURANCE COMPANY PROVIDING BENEFITS</b>		<b>ADDRESS OF INSURANCE COMPANY PROVIDING BENEFITS</b>

Is premium for other insurance coverage paid by Employer? \_\_\_\_\_ Yourself? \_\_\_\_\_ Spouse? \_\_\_\_\_

TOTAL PREMIUM: \_\_\_\_\_

Amount of Premium paid by myself or spouse? \_\_\_\_\_ Amount paid by Employer? \_\_\_\_\_

**Complete if Claim Is For Dependent**

Name of Dependent _____	Relationship to Member _____	Date of Birth _____
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I hereby authorize any insurance company, employer or organization to release or obtain any information necessary to determine benefits paid or payable concerning this or other disabilities. Also, I certify that, to the best of my knowledge, the above information is true and correct. I understand that failure to answer these questions truthfully could forfeit payment of benefits under my insurance coverage. A copy of this authorization shall be as valid as the original.

Employee's signature: \_\_\_\_\_ Date Completed: \_\_\_\_\_

**Administrator's Statement**

I certify the above member was, at the time of the loss reported here, eligible for insurance benefits.

Dated \_\_\_\_\_, 19\_\_\_\_. Administrator's signature: \_\_\_\_\_

