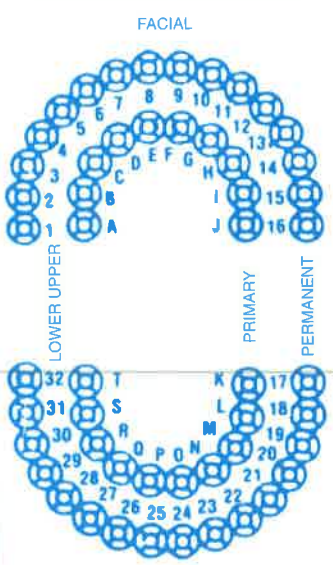
IRONWORKER'S INTERMOUNTAIN TRUST FUND

MAIL TO: P.O. Box 30124 • Salt Lake City, Utah 84130-0124
2156 West 2200 South • Salt Lake City, Utah 84119
Telephone 801-606-2425 • Toll Free 888-867-9510

PATIENT NAME	PATIENT BIRTHDATE MO DAY YEAR	RELATIONSHIP TO EMPLOYEE	SEX
		SELF / SPOUSE / CHILD	M / F
EMPLOYEE NAME: (FIRST) (INITIAL) (LAST) **(Insured)**		SOCIAL SECURITY NUMBER	LOCAL UNION NUMBER
ADDRESS		IS PATIENT COVERED BY OTHER PLAN? ❑ YES ❑ NO	POLICY NUMBER
CITY, STATE, ZIP		NAME OF EMPLOYEE UNDER OTHER PLAN	EMPLOYEE SOC. SEC.
DENTIST NAME		NAME & ADDRESS OF OTHER INSURANCE COMPANY	
MAILING ADDRESS		IS ANY OF TREATMENT FOR ORTHODONTIC PURPOSES?	YES / NO
CITY, STATE, ZIP		TREATMENT RESULT OF ACCIDENT?	
TELEPHONE		RESULT OF OCCUPATIONAL INJURY?	
DENTIST SOCIAL SECURITY OR I.R.S. TAX NUMBER		IF PROSTHESIS, IS THIS INITIAL PLACEMENT	YES / NO / DATE OF PRIOR PLACEMENT

PLEASE PLOT WORK

IDENTIFY MISSING TEETH WITH "X"



EXAMINATION AND TREATMENT RECORD – LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 USE CHARTING SYSTEM SHOWN.

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO DAY YR	PROCEDURE NUMBER	FEE	BENEFIT ALLOWED

SIGN BELOW FOR PAYMENT

I hereby certify the statements herein are complete and I authorize my attending dentist to release any information relating to the claim.

PATIENT/PARENT OR EMPLOYEE SIGNATURE X _____ DATE _____

EMPLOYEE'S ASSIGNMENT TO BE COMPLETED AND SIGNED IF DIRECT PAYMENT OF DENTAL BENEFITS IS DESIRED.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED THE CHARGES SHOWN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION.

PATIENT/PARENT OR EMPLOYEE SIGNATURE X _____ DATE _____

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED AND TO THE BEST OF MY KNOWLEDGE ARE WITHIN THE PROVISIONS OF THE ABOVE DENTAL PLAN, PAYMENT IS THEREFORE DUE.

DENTIST SIGNATURE X _____ DATE _____

TOTAL FEE CHARGED $

INS. PAYS AT % $

DRAFT NO.

DATE / BY

Ineligible Charges

Year to Date Paid