



**CENTRAL STATES  
SOUTHEAST AND  
SOUTHWEST AREAS  
HEALTH AND WELFARE FUND**

**MAIL TO: Central States Southeast and Southwest Areas  
Health and Welfare Fund  
Claims Processing – Dental**

PO Box 5104 Des Plaines IL 60017-5104  
1-800-323-5000

**DO NOT WRITE ABOVE THIS LINE.  
FOR OFFICE USE ONLY.**

**PART 1 – MEMBER**

<b>MEMBER'S SOC. SECURITY NUMBER</b>		<b>MEMBER'S FIRST NAME</b>		<b>MIDDLE INITIAL</b>	<b>LAST NAME</b>		<b>MEMBER'S BIRTH DATE</b>			<b>SEX</b>	
							<b>MONTH</b>	<b>DAY</b>	<b>YEAR</b>	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>IF ADDRESS HAS CHANGED SINCE LAST CLAIM PLACE X IN THIS BOX.</b>		<b>MEMBER'S STREET ADDRESS</b>			<b>MEMBER'S CITY &amp; STATE</b>			<b>ZIP CODE</b>			
<b>LOCAL UNION</b>	<b>EMPLOYER NAME</b>				<b>MEMBER'S MARITAL STATUS</b>						
					<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed						
<b>PATIENT'S NAME</b>		<b>RELATIONSHIP TO MEMBER</b>				<b>PATIENT'S BIRTHDATE</b>			<b>Is Patient covered by other Group Dental Plan?</b>		
		<input type="checkbox"/> Self <input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Other (explain) _____				<b>MONTH</b> <b>DAY</b> <b>YEAR</b>			<input type="checkbox"/> YES <input type="checkbox"/> NO		
<b>THESE QUESTIONS MUST BE ANSWERED</b>		<b>FIRST NAME OF SPOUSE</b>	<b>Is your Spouse employed?</b>	<b>Does your Spouse have Group Dental coverage?</b>	<b>SPOUSE'S SOC. SEC. NUMBER</b>			<b>Spouse's Birthdate</b>	<b>MONTH</b>	<b>DAY</b>	<b>YEAR</b>
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No							
<b>SPOUSE'S EMPLOYER PROVIDING COVERAGE</b>		<b>ADDRESS OF SPOUSE'S EMPLOYER (STREET, CITY, STATE &amp; ZIP CODE)</b>									
<b>SPOUSE'S INSURANCE COMPANY NAME &amp; ADDRESS (STREET, CITY, STATE &amp; ZIP CODE)</b>							<b>GROUP NUMBER</b>		<b>POLICY NUMBER</b>		
<b>AUTHORIZATION</b>					<b>ASSIGNMENT OF BENEFITS</b>						
I hereby authorize release of any study models, x-rays and information relating to this claim.					I hereby certify that the dated services listed below have been rendered and I authorize benefit payment directly to the below-named orthodontist/dentist.						
_____					_____						
<b>SIGNED (Patient, or Parent if Minor)</b>					<b>SIGNED (Member)</b>						
<b>Date</b>					<b>Date</b>						

