Refer Completed Claims and Questions to:
UFT Welfare Fund c/o
Connecticut General
Life Insurance Co.
P.O. Box 182531
Chattanooga, TN 37422-7531
1-800-577-0576

CIGNA HealthCare

DENTAL FORM

UFT
UNITED FEDERATION OF TEACHERS
WELFARE FUND
LOCAL 2, AMERICAN FEDERATION OF TEACHERS, AFL-CIO

❑ **PRE-TREATMENT ESTIMATE**
(REQUIRED FOR INLAYS, CROWNS, LAMINATE VENEERS, BRIDGES, DENTURES, PERIODONTAL SURGERY OR WHEN EXPENSES WILL EXCEED $500 IN A 90 DAY PERIOD)

❑ **PAYMENT CLAIM**
PLEASE SUBMIT PRE-TREATMENT X-RAYS FOR NON-ROUTINE EXTRACTIONS AND PRE- AND POST-TREATMENT X-RAYS FOR ROOT CANAL THERAPY

❑ ACTIVE MEMBER
❑ RETIREE
❑ COBRA

❑ **Yes - Spouse/Domestic Partner is a UFT Member therefore eligible for Special C.O.B.**

Spouse/Domestic Partner Social Security Number

MEMBER INFORMATION – See instructions on reverse side

Member Name *(Please Print)*	Birthdate	Sex	Social Security #

Home Address	City	State	Zip Code	Telephone #
				( )

School or Bureau	School Telephone #	Do you have G.H.I. medical coverage?
	( )	❑ Yes ❑ No

Name and Address of Other Company/Organization Providing Dental Benefits under which you are covered

PATIENT INFORMATION

Patient Name *(Please Print)*	Birthdate	Relationship to Member

SPOUSE/DOMESTIC PARTNER INFORMATION – (Required if claim is for Spouse/Domestic Partner or Dependent Child)

Spouse/Domestic Partner Name *(Please Print)*	Spouse/Domestic Partner Birthdate	Spouse/Domestic Partner Social Security #

Is spouse/domestic partner covered by another Dental Benefits Plan other than UFTWF? ❑ Yes ❑ No If yes, specify below.

Name and Address of Other Company/Organization Providing Dental Benefits	Company/Organization Telephone #
	( )

AUTHORIZATION (Authorization to release information must be signed or payment will not be made)

To Release Information: I have reviewed the following treatment plan. I authorize release of any and all information relating to this claim.

Signed (Patient or Parent if Minor)_____ Date _____

To Assign Benefits: I hereby authorize payment directly to the below named dentist of the benefits otherwise payable to me. I understand I am financially responsible to the dentist for charges not covered by this assignment. This authorization is invalid unless the TAX ID # of the provider is given below.

Signed (Member) _____ Date _____

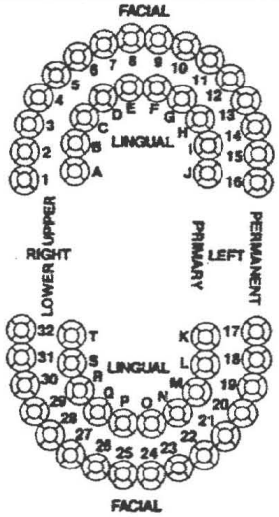
DENTIST INFORMATION – (See instructions on the back regarding the need for x-rays)

Dentist's Name *(Please Print)*	License #	Taxpayer ID #

Street Address	City	State	Zip Code	Telephone #
				( )

If prosthesis, is this the initial placement?	Date of Prior Placement
❑ Yes ❑ No If no, the reason for replacement	

DENOTE MISSING TEETH WITH AN "X"



PLEASE CHART PROPOSED OR RENDERED TREATMENT

Are radiographs enclosed? If yes, how many?
❑ Yes ❑ No

Is this claim the result of: Accident Injury ❑ Yes ❑ No
Motor Vehicle Injury ❑ Yes ❑ No

PATIENT'S NAME **AGE:**

Tooth # or letter	Surface	Description of Service (including materials used)	Date Service Performed	Procedure Code	Fee

I hereby certify the accuracy of the pre-treatment estimate and/or procedures and, if completed, the dates of completion as listed above.
Was a pre-treatment filled by another provider? ❑ Yes ❑ No

Signed (Dentist) _____ Date _____

TOTAL FEE CHARGED