Mail all copies to:

COMPUSYS
2156 West 2200 South • Salt Lake City, Utah 84119-1376
Telephone: (801) 973-1010

Utah Laborer's Health and Welfare Trust Fund

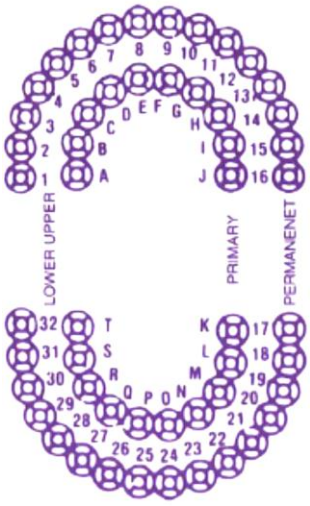
PATIENT NAME	PATIENT BIRTHDAY MO DAY YEAR	RELATIONSHIP TO EMPLOYEE SELF / SPOUSE / CHILD	SEX ☐ M ☐ F	IS CHILD A FULL-TIME STUDENT ☐ YES ☐ NO

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? ☐ YES ☐ NO	
TELEPHONE		RESULT OF OCCUPATIONAL INJURY? ☐ YES ☐ NO	
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 THEETH WITH "X"

FACIAL



FACIAL

EXAMINATION AND TERATMENT 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