Aetna®

Dental Benefits Request

RAILROAD EMPLOYEES
NATIONAL DENTAL PLAN GP-12000

How To Request Benefits

Employee Instructions

Complete **Items 1 - 18A** in the **PATIENT INFORMATION** section of this form and sign your name. If you wish your benefits paid directly to your dentist, also sign **Item 18B**, the payment authorization.

Ask the dentist to complete **Items 19 - 34** in the **DENTIST INFORMATION** section. If charges are only for examinations, cleanings or X-rays, itemized bills may be submitted instead of the dentist's portion of the form. The itemized bill must include:

- patient's name
- date of service
- condition being treated
- relationship to employee
- type of service rendered
- dentist's or supplier's taxpayer identifying number

If this information is missing, write it on the bill and sign your name.

Please be sure you have provided your **SOCIAL SECURITY NUMBER** (**Item 7**), your **EMPLOYEE NUMBER** (**Item 14**) if you have one, and the **NAME OF THE UNION** (**Item 13**) that represents you.

You or your dentist should submit the completed attending dentist's statement to:

Aetna Dental™
P.O. Box 14094
Lexington, KY 40512-4094
1-877-277-3368

IF YOU ANTICIPATE DENTAL WORK IN EXCESS OF **$300**, SUBMIT A REQUEST FOR A PRE-TREATMENT ESTIMATE OF BENEFITS. ACTUAL PAYMENT MAY DIFFER FROM THE ESTIMATE. SEE BOOKLET FOR MORE INFORMATION.

NOTE: *BE SURE YOU ARE ELIGIBLE FOR DENTAL BENEFITS.*

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant.
California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.
Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.
Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Dentist Instructions

Complete **Items 19-34** on the Benefit Request Form **including tooth chart**. Indicate whether the form represents a request for a pre-treatment estimate or is a statement of services actually rendered by checking the box on the top of the form.

For a pre-treatment estimate, **LEAVE THE DATE BLANK** for those services that have not been completed. Our estimate and your X-rays will be returned to you promptly. Estimates are subject to deductibles and plan maximums and may be reduced by payments made before these services are rendered. The estimate is based on the assumption the patient will receive the services while covered and the treatment plan does not change.

Actual payment may differ from estimate.

NOTE ABOUT X-RAYS: *In order to expedite payment it is suggested the **PRE-TREATMENT X-RAYS** be submitted along with the Benefit Request Form when the course of treatment includes prosthetics (including all cast and porcelain restorations), oral surgery and periodontal surgery. You will be advised if x-rays are needed for any other procedure.*

BENEFIT REQUEST — DENTAL

RAILROAD EMPLOYEES
NATIONAL DENTAL PLAN GP-12000

CHECK ONE:
☐ DENTIST'S PRE-TREATMENT ESTIMATE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

IF NOT WORKING FOR THIS RAILROAD SHOW REASON(S)
☐ DISABLED ☐ PREGNANCY ☐ DISMISSED
☐ RESIGNED ☐ LEAVE OF ABSENCE
☐ FURLOUGH ☐ SUSPENDED ☐ RETIRED EFF. DATE _____

PATIENT INFORMATION

1. PATIENT NAME (FIRST MIDDLE INITIAL LAST)

2. RELATIONSHIP TO EMPLOYEE: SELF | SPOUSE | CHILD | STEP-CHILD

3. SEX: M | F

4. PATIENT BIRTHDATE: MO. DAY YR

5. IF PATIENT IS A FULL TIME STUDENT: SCHOOL CITY
GRADUATION DATE

6. EMPLOYEE NAME (FIRST MIDDLE INITIAL LAST)

7. EMPLOYEE SOCIAL SECURITY NUMBER ___ ___ ___ - ___ ___ - ___ ___ ___ ___

8. EMPLOYEE'S BIRTHDATE: MO. DAY YR

9. EMPLOYEE ADDRESS IS THIS A NEW ADDRESS? ☐ YES ☐ NO

CITY STATE ZIP TELEPHONE NUMBER ( )

10. NAME OF RAILROAD MO. & YEAR EMPLOYED

11. RAILROAD DIVISION, DEPARTMENT & LOCATION (CITY & STATE)

12. EMPLOYEE OCCUPATION

13. NAME OF UNION BY WHICH YOU ARE REPRESENTED

14. EMPLOYEE NUMBER

15. LOCATION (LOCAL)

16. ARE OTHER FAMILY MEMBERS EMPLOYED? ☐ YES ☐ NO
EMPLOYEE NAME SOCIAL SECURITY NUMBER
IF "YES", WHERE:

17. NAME AND ADDRESS OF EMPLOYER IN ITEM 16.

18. DO YOU HAVE **OTHER** DENTAL COVERAGE COVERING YOU OR A FAMILY MEMBER? (CHECK ONE) ☐ YES ☐ NO

- IF "YES", WHO'S COVERED? ☐ YOURSELF ☐ SPOUSE ☐ OTHER DEPENDENT ☐ IF SPOUSE OR OTHER DEPENDENT, GIVE FULL NAME _____ BIRTHDATE _____
- IF "YES", PROVIDE THE FOLLOWING: NAME & ADDRESS OF INSURANCE COMPANY OR OTHER CARRIER PROVIDING COVERAGE _____ POLICYHOLDER CERTIFICATE NUMBER OF OTHER COVERAGE _____

18A. To all providers of dental care:
You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting dental professionals and utilization review organizations with whom Aetna has contracted, information concerning dental care, advice, treatment or supplies provided the patient. This information will be used to evaluate claims for dental benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Patient's or Authorized Person's Signature _____ Date _____

18B. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST FOR THE SERVICES DESCRIBED BELOW.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE _____ DATE _____

DENTIST'S INFORMATION

19. DENTIST NAME

20. MAILING ADDRESS IS THIS A NEW ADDRESS? ☐ YES ☐ NO

CITY STATE ZIP

21. ENTER THE TAXPAYER IDENTIFYING NUMBER TO BE USED FOR 1099 REPORTING PURPOSES. YOU ARE REQUIRED UNDER AUTHORITY OF LAW TO FURNISH YOUR TAXPAYER IDENTIFYING NUMBER

22. DENTIST LICENSE NUMBER

23. DENTIST TELEPHONE NUMBER ( )

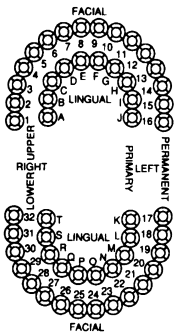
24. FIRST VISIT DATE CURRENT SERIES

25. PLACE OF TREATMENT: OFFICE | HOSP. | ECF | OTHER

26. RADIOGRAPHS OR MODELS ENCLOSED: NO | YES | HOW MANY?

		NO	YES	
27.	IS TREATMENT RESULT OF OCCUPATIONAL INJURY OR ILLNESS			
28.	IS TREATMENT RESULT OF AUTO ACCIDENT?			
29.	OTHER ACCIDENT?			
30.	ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
31.	IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF "NO", REASON FOR REPLACEMENT) — 32. DATE OF PRIOR PLACEMENT?
33.	IS THE TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED _____ MOS. TREATMENT REMAINING _____

IDENTIFY MISSING TEETH WITH "X"



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

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO.	DAY	YR.	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE ACTUAL FEES I HAVE CHARGED THIS PATIENT AND INTEND TO ACCEPT FOR THOSE PROCEDURES.

DENTIST'S SIGNATURE DATE

TOTAL FEE CHARGED

Plan Maximum

Payable Now