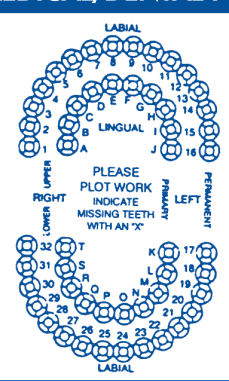


# UNITED FOOD AND COMMERCIAL WORKERS & EMPLOYERS

## Arizona Health & Welfare Trust SSA MEXICO PPO NETWORK

2400 W. Dunlap Ave., Suite 250 \* Phoenix, AZ 85021 \* Phone 602-249-3582 \* Toll Free 1-800-474-3485 \* Fax 602-249-3795  
www.southwestservicetpa.com

PART A		EMPLOYEE'S STATEMENT	MUST BE COMPLETED BY EMPLOYEE		PLEASE PRINT
1. EMPLOYEE NAME			2. BIRTH DATE		3. SS#
			MO.	DAY	YR.
4. ADDRESS <input type="checkbox"/> CHECK HERE IF NEW ADDRESS		CITY	STATE	ZIP	5. PHONE NO.
6. CLAIM IS FOR <input type="checkbox"/> SPOUSE <input type="checkbox"/> SELF <input type="checkbox"/> CHILD		7. DEPENDENT'S NAME		8. RELATIONSHIP	
10. EMPLOYER		11. EMPLOYER ADDRESS		9. BIRTH DATE	
				MO.	DAY YR.
13. IS THIS CLAIM FOR AN ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		14. IF YES - WHERE DID IT HAPPEN?		15. WHEN?	
				MO.	DAY YR.
16. DID THIS ACCIDENT/INJURY OCCUR ON THE JOB? <input type="checkbox"/> YES <input type="checkbox"/> NO					
17. DESCRIBE WHAT HAPPENED					
18. EMPLOYEE STATEMENT AND AUTHORIZATION TO RELEASE INFORMATION: I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize any physician or any hospital to furnish and disclose all known facts concerning this disability. I will reimburse the fund for any overpayment made to me or in my behalf due to error on this form. I understand that it is a federal crime, punishable by fine or imprisonment, or both, to knowingly make false statements on this benefit claim form.					
Employee Signature: X _____			Date _____		
CLAIM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE			MO.	DAY	YR.

PART B		PROVIDER'S STATEMENT			MUST BE COMPLETED BY PROVIDER		MEDICAL/DENTAL FORM	
1. PATIENT'S NAME				2. AGE	3. SEX		 <p style="text-align: center;">PLEASE PLOT WORK INDICATE MISSING TEETH WITH AN 'X'</p>	
4. DIAGNOSIS OR NATURE OF DISEASE, INJURY CLAIM OR VISION DISORDER								
5. OCCUPATIONAL INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO								
6. DATE OF SERVICE	PLACE OF SERVICE	TOOTH #	SURFACE	CPT or CDT	LIST SEPARATELY: SERVICES, MATERIALS AND FITTINGS		CHARGES	
MO. DAY YR.								
<b>NOTE: Provider ID No. (No. 7) Must Be Completed</b>		7. PROVIDERS MX#		8. TELEPHONE NO.		9. DATE		TOTAL CHARGES
10. PROVIDER'S NAME AND DEGREE (PRINT)				11. SIGNATURE X			AMOUNT PAID	
12. ADDRESS			13. CITY		14. STATE		15. ZIP	
							BALANCE DUE	