ALLIED PILOTS ASSOCIATION
VOLUNTARY SUPPLEMENTAL MEDICAL AND CUSTODIAL CARE BENEFIT PLAN DENTAL CLAIM FORM

Return completed form to:

Luminare Health
P.O. Box 4187
Clinton, IA 52733-4187
1-877-498-8937

DENTAL BENEFITS ARE FOR PILOTS COVERED UNDER THE RETIREE MEDICAL PLAN, SURVIVING SPOUSES, RETIRED STAFF AND THEIR COVERED DEPENDENTS.

ORTHODONTIA BENEFITS ARE FOR ACTIVE PILOTS, FURLOUGHED PILOTS, TAG MEMBERS, PILOTS ON MEDICAL DISABILITY AFTER 2/1/04, SURVIVING SPOUSES AND THEIR COVERED DEPENDENTS. SEND IN A COPY OF YOUR EXPLANATION OF BENEFITS FROM METLIFE AND A COPY OF THE ORTHODONTIA TREATMENT PLAN.

NOTE: DENTAL CLAIMS MUST BE FILED WITHIN 12 MONTHS OF DATE OF SERVICE. ORTHODONTIA CLAIMS MUST BE FILED NO LATER THAN 12 MONTHS FROM THE DATE THE TREATMENT ENDED.

SECTION A
Complete this section for all claims.

Name *(Last, First, Middle Initial)* | Employee Number | Social Security Number | Gender ☐ Male ☐ Female

Mailing Address *(☐ Check if new address)*

City, State, Zip Code | Date of Birth *(Month/Day/Year)* | ☐ Married ☐ Single

Day Telephone Number | Second Telephone Number | Status *(Check one)* ☐ Active ☐ Retired ☐ Medical Disability ☐ Surviving Spouse ☐ TAG ☐ Furloughed

SECTION B
Complete this section for Dependent claims only,

Patient Name *(Last, First, Middle Initial)* | Patient Social Security Number

Patient Gender ☐ Male ☐ Female | Patient Date of Birth *(Month/Day/Year)* | Relationship to Employee ☐ Spouse ☐ Child/Dependent | Patient Marital Status ☐ Married ☐ Single

SECTION C
Complete this section for all claims.

Are you or your spouse or your dependent covered or eligible for dental or orthodontia coverage under any other group plan? ☐ Yes ☐ No

YOU MUST PROVIDE AN EXPLANATION OF BENEFITS FROM YOUR OTHER COVERAGE BEFORE BENEFITS CAN BE PAID UNDER THIS PLAN.

SECTION D
Complete this section for all claims.

ASSIGNMENT OF BENEFITS

Do you want us to pay the provider? (Doctor. Hospital, etc.) ☐ Yes ☐ No ***If Yes, please sign below.***

I hereby authorize payment of benefits otherwise payable to me up to the stated charges to the provider(s) of services for all bills included with this statement. I understand I am financially responsible for any amounts not payable or not covered by the plan.

Member Signature *(DO NOT sign here if you want the payment sent to YOU.)* | Date

SECTION E
Complete this section for all claims.

CERTIFICATION AND AUTHORIZATION

I certify that all the above statements are correct and complete and that the attached bill(s) represent actual services, dates and fees charged to me or my Eligible Dependents. I authorize the Plan and Its agents to take any appropriate action to receive expenses paid as the result of the acts or omissions of another person. To all Physicians, Hospitals, medical service providers, pharmacists, employers and other agencies or organizations: I agree that Luminare Health and their authorized representatives may see or obtain a copy of all medical, mental and dental care, drug or alcohol treatment prescribed drug, employment and insurance coverage records necessary for the proper administration of the Plan which pertains to patient. Such Information may be used to the extent deemed necessary by Luminare Health to determine the value or amount payable on account of this claim.

Member Signature | Date | Patient Signature *(if different)* | Date

NOTE: A photocopy of the above authorization is as valid as the original.