The Order of United Commercial Travelers of America • A Fraternal Benefit Society
Mailing Address:
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Home Office: 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215 - 8619

Dental, Vision & Hearing Expense Insurance Policy Claim Form

Please select the type of benefit you are filing: ☐ Dental ☐ Vision ☐ Hearing

PATIENT INFORMATION (COMPLETE ALL QUESTIONS) **Today's Date (MM/DD/YYYY): ______/______/______**

1. Name: ______________________________ **Policy Number:** ______________
   First, MI, Last
2. Address: ____
   Street City Prov. Postal Code
   Email Address: ______________________________
3. Date of Birth: ______/______/______ 4. Sex: ☐ Male ☐ Female 5. Phone: (________)__________________
   Month/Day/Year

Separate claim forms are required for each date of service you are filing.
Please provide an itemized statement from the Provider which includes a description of services rendered.

PLEASE COMPLETE IN FULL AND RETURN WITHIN 90 DAYS OF DATE OF SERVICE

Claim Information For DENTAL BENEFITS Check the item of service rendered.

6. ☐ Examination & Cleaning ☐ X-Rays ☐ Fillings ☐ Prophylaxis ☐ Other, please specify:
   ☐ Outpatient Dental Surgery ☐ Bridges ☐ Crowns ☐ Dentures ______________________
7. Date of Service: _______/_______/_______
   Month/Day/Year

Claim Information For VISION BENEFITS Check the item of service rendered.

8. ☐ Eye Examination or Eye Refraction ☐ Eye Glasses ☐ Contact Lenses ☐ Other, please specify:
9. Date of Service: _______/_______/_______ ______________________
   Month/Day/Year

Claim Information For HEARING BENEFITS Check the item of service rendered.

10. ☐ Hearing Examination ☐ Hearing Aid ☐ Hearing Aid Repair ☐ Other, please specify:
11. Date of Service: _______/_______/_______ ______________________
    Month/Day/Year

12. Name(s) of Provider providing services for this claim:
13. Address: ____ (_______)______________
    Street City Prov. Postal Code Phone Number (including area code)

Any person who knowingly and with intent to defraud any insurance company or other person, files a 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.

ANY COST FOR COMPLETION OF THIS FORM IS THE RESPONSIBILITY OF THE PATIENT

Date: _______/_______/_______ Signature: **X** ______________________________________
Month/Day/Year (Signature of Claimant or Representative)

If signed by a guardian or a power of attorney, we must have notarized papers verifying this.

Insured's Name: ______________________________ Policy No. ____________________

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I authorize any physician, medical practitioner, hospital, clinic other medical or medically related facility, insurance or reinsuring company, consumer reporting agency or employer, having information available as to diagnosis, treatment and prognosis with respect to my physical or mental condition and/or treatment and any other non-medical information, to give The Order of United Commercial Travelers of America or its legal representative, any and all such information.

I understand the information obtained by use of the authorization will be used by The Order of United Commercial Travelers of America to determine eligibility for benefits under an existing policy. Any information obtained will not be released by The Order of United Commercial Travelers of America to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

I know that I may request to receive a copy of this authorization.

I agree that a photographic copy of this authorization shall be as valid as the original.

I understand that I am not required to sign this authorization form and that UCT will not condition the provision of payment for benefits to me on the signing of this authorization. However, UCT may condition payment of a claim for benefits on my authorization for disclosure of my information held by another person or entity, if such information is necessary to determine payment of a claim.

I agree that this authorization shall be valid for one year from the date shown below.

Release of all treatment records from: ____________________ to: ____________________
Month/Day/Year Month/Day/Year

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by Canadian Privacy regulations, the information above may be re-disclosed by such person or entity and will likely no longer be protected by the Canadian Privacy regulations.

As described in the *Notice of Privacy Practices* of UCT. I understand that I may revoke this authorization in writing at anytime, except to the extent that action has already been taken by UCT in reliance on this authorization, by sending a written revocation to UCT, Privacy Officer, 1801 Watermark Drive, Suite 100, Columbus, OH 43215.

Name of Insured: ______________________________ Social Insurance No.: ____________________

Date: _______/_______/_______ Signature: X ____
Month/Day/Year (Signature of Insured or Representative)

If signed by a guardian or a power of attorney, we must have notarized papers verifying this.

Benefits: After the Policy Year Deductible is satisfied the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Maximum Benefit:

1. **60% in the first Policy Year**
2. **70% in the second Policy Year**
3. **80% in the third Policy Year**
4. **90% thereafter**

Covered Expenses, subject to the Limitations and Exclusions, are:

1. **Dental services, performed by a licensed Dentist, including one annual examination and cleaning, x-rays, fillings, prophylaxis, bridges, crowns, dentures and outpatient dental surgery prescribed as Medically Necessary.**
2. **Visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit of $150 in any one (1) Policy Year.**
3. **Hearing examinations performed by a Physician or Audiologist, including the cost of the hearing aid and any necessary repairs.**

After the Policy has been in force three (3) months, the cost of one (1) dental cleaning up to a maximum benefit of $75 each Policy Year. This benefit is not subject to the Policy Year Deductible; however, it is included in the Policy Year Maximum Benefit.

We will pay all benefits to You; benefits under this Policy are not subject to assignment.

Please be sure to read the LIMITATIONS and EXCLUSIONS section of your policy for additional information on eligible expenses.