THE IRONWORKERS LOCAL 764 **BENEFIT TRUST FUND GROUP DENTAL CLAIM FORM**

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Date of Service PROCEDURE INT. TOOTH TOOTH SURFACES PROCEDURE CODE SURFACES PROCEDURE CODE SURFACES PROCEDURE CODE SURFACES PLASE SUBMIT CLAIM FORM TO Marion, Wilkins & Associates Ltd 628 - 21 Four Seasons Place Eloblocko ON MB DAB 1-800-263-5621 (Tol Free) Plan Administrator Use Only Policy Number: 00380000 THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE EAGO Member Address City / Town Prov Postal Code Insurance Company Name City / Town Prov Postal Code Insurance Company Name If initial placement, advise the date teeth were attracted and all other missing teeth. Date: If initial placement advised the date teeth were attracted and all other missing teeth. Date: If initial placement is the string of crown, is this an initial placement. Date: If initial placement is the date teeth were attracted and all other missing teeth. Date: If it is dependent working? Is this dependent is the date teeth were attracted and all other missing teeth. Date: Is this dependent is the date of prior placement and reason for replacement. Date: I fereit replacement and reason for replacement. Date: Date: I fereit replacement and reason for replacement. Date: Date: I fereit replacement and							GNOSIS,	plan benefits. I understand I am financially responsible to my dentist for the entir treatment. I acknowledge that the total fees of \$						o my dentist for the entire is accurate and		
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