



(845) 562-7988 • 52 Pierces Road • Newburgh, NY 12550

CONFIDENTIAL

Dental Benefits Claim Form

- 1) All sections of this form must be completed by the member.
- 2) Attach a copy of the "Dentist's Statement of Services" to this form and return both within 90 days of date of service to the above address via U.S. Mail or District courier.
- 3) *Do not* give claims to your dentist to file for you.
- 4) The member is responsible for knowledge of all Trust Fund rules and regulations.

Patient Name		Patient Date of Birth Month Day Year		Patient Relationship to Member	
Is Treatment the Result of an Accident? Yes <input type="checkbox"/> No <input type="checkbox"/>				Are X-Rays Enclosed Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, How Many?	
Is Treatment the Result of Occupational Injury? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Is Patient Covered by Another Insurance Plan? Yes <input type="checkbox"/> No <input type="checkbox"/>			Name of Other Plan		
Name of Member		D.O.B. / /	M F <input type="checkbox"/> <input type="checkbox"/>	Indicate your job title:	
Name of Spouse		D.O.B. / /	M F <input type="checkbox"/> <input type="checkbox"/>	Teacher <input type="checkbox"/> Individual Contract <input type="checkbox"/> SRP <input type="checkbox"/> Administration <input type="checkbox"/> Retired <input type="checkbox"/> COBRA <input type="checkbox"/> School	
We certify that the foregoing statements and answers are true and complete to the best of our knowledge and belief. A photo copy of this claim form shall be considered as effective and valid as the original.					
Date	Signature of Member			Fund Use Only	Fund Use Only
Address					
City	State	Zip Code			

