BENEFIT TRUST FUND

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

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?	Are X-Rays Enclosed	If Yes, How Many?
Yes ☐ No ☐	Yes ☐ No ☐	

Is Treatment the Result of Occupational Injury?	Patient Covered By Other Insurance? If Yes, Name The Other Plan
Yes ☐ No ☐	Yes ☐ No ☐ Other Plan ☐

Name of Member	D.O.B	Male/Female	Indicate your job title:
	/ /	M ☐ F ☐	Teacher ☐ T/A ☐ COBRA ☐ Contract Individual ☐ Administration ☐ Retired ☐ SRP ☐
Name of Spouse	D.O.B	Male/Female	
	/ /	M ☐ F ☐	
School			

We certify that the foregoing statements and answers are true and complete to the best of our knowledge and belief. A photocopy of this claim form shall be considered as effective and valid as the original.

Date _____ Signature of Member _____

Address _____ City, State, Zip Code _____

Fund Use Only ☐ Fund Use Only ☐