

# 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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	

Is Treatment the Result of Occupational Injury?	Patient Covered By Other Insurance? If Yes, Name The Other Plan
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Other Plan <input style="width: 100px;" type="text"/>

Name of Member	D.O.B / /	Male/Female M <input type="checkbox"/> F <input type="checkbox"/>	Indicate your job title:	
Name of Spouse	D.O.B / /	Male/Female M <input type="checkbox"/> F <input type="checkbox"/>	Teacher <input type="checkbox"/>	Contract Individual <input type="checkbox"/>
			T/A <input type="checkbox"/>	Administration <input type="checkbox"/>
			COBRA <input type="checkbox"/>	Retired <input type="checkbox"/>
			SRP <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 photocopy of this claim form shall be considered as effective and valid as the original.

		Fund Use Only	Fund Use Only
Date	Signature of Member		
Address	City, State, Zip Code		