

**NEW YORK STATE TEAMSTERS COUNCIL
HEALTH AND HOSPITAL FUND**

P.O. Box 4928 • Syracuse, NY 13221-4928
Telephone: 315-455-9790
Fax: 315-455-1271

Do not write in the above space.

IMPORTANT DENTAL CLAIM INSTRUCTIONS

1. Fees should be discussed with the dentist before treatment begins.
2. A predetermination of allowances with appropriate radiographs is:
 - a. mandatory for dentures, crowns, bridge work and orthodontic treatment
 - b. recommended for root canal therapy, periodontal treatment, extensive oral surgery or when total charges will exceed \$300.
3. Claim forms must be submitted within 90 days of the date of service for which charges are being submitted or benefits will be denied. Claim forms should be mailed to the Fund Office at the above address.
4. All benefits will be paid to the member unless the dentist agrees to accept the Fund's benefits as payment in full for covered services. If benefits are to be paid to the dentist, both the employee and dentist should sign the assignment on the reverse side of this form.

EMPLOYEE STATEMENT

I hereby apply for benefits for self spouse unmarried dependent child in connection with dental care or treatment not arising out of or in connection with employment. The Fund shall have the right to obtain from or release to any insurance company, organization, employer or other person information regarding this claim.

Employee Signature _____ Date _____

1. Employee Soc. Sec. No. — —	2. Employee Name – First	M.I.	Last	3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Telephone No. () —
5. Address – Street	City	State	Zip Code	6. Date of Birth (Mo/Day/Yr)	
7. Name of Employer			8. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		
9. Are you or any of your dependents covered under another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete item 10.					
10. Dental Plan Name	Group Number (If known)		Name and Address of Carrier		

COMPLETE THE FOLLOWING INFORMATION IF THE CLAIM IS FOR A SPOUSE OR DEPENDENT CHILD

1. Spouse's Soc. Sec. No. — —	2. Spouse's Name – First	M.I.	Last	3. Telephone No. (if different from employee's) () —
4. Address (if different from employee's) Street	City	State	Zip Code	5. Date of Birth (Mo/Day/Yr)
6. Is Spouse Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	7. Name and Address of Spouse's Employer			

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT. THIS IS A CRIME.

