PLEASE MAIL CLAIM FORMS TO:

SERVICE EMPLOYEES BENEFIT FUND

P.O. Box 1600 • Syracuse, New York 13201

EMPLOYEE

1. PATIENT'S NAME	2. RELATIONSHIP TO EMPLOYEE (SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐)	3. SEX (M ☐ F ☐)	4. PATIENT BIRTHDATE (MO / DAY / YEAR)	5. IS PATIENT DEPENDENT STUDENT AGE 19 OR OVER? IF YES, YOU MUST COMPLETE REVERSE SIDE OF FORM (YES ☐ NO ☐)

6. EMPLOYEE'S NAME (LAST / FIRST / INITIAL)	9. SOCIAL SECURITY NO.
7. EMPLOYEE'S MAILING ADDRESS	10. EMPLOYER
CITY, STATE, ZIP — 8. HOME PHONE	11. EMPLOYEE'S BIRTHDAY MO: DAY: YR: / SPOUSE'S BIRTHDAY MO: DAY: YR:

12. IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO — IF "YES" GIVE NAME AND ADDRESS OF YOUR SPOUSE'S EMPLOYER

13. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO	14. NAME AND ADDRESS OF INSURANCE CARRIER	15. GROUP NUMBER

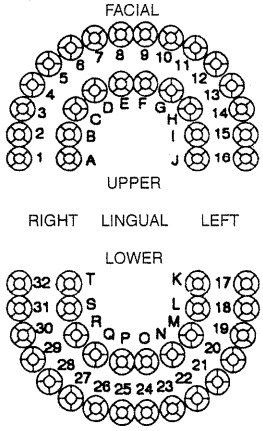
16. I CERTIFY THAT THE INFORMATION GIVEN IS CORRECT AND AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM. BENEFITS ARE NOT AVAILABLE UNDER ANY OTHER GROUP PLAN EXCEPT AS INDICATED ABOVE.
EMPLOYEE SIGN HERE ▶ _____ DATE _____

17. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.
EMPLOYEE SIGN HERE ▶ _____ DATE _____

DENTIST

18. DENTIST NAME	25. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
19. MAILING ADDRESS	26. IS TREATMENT RESULT OF AUTO ACCIDENT?			
	OTHER ACCIDENT?			
CITY, STATE, ZIP	27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
20. DENTIST SOC. SEC. OR T.I.N. 21. DENTIST LICENSE NO. 22. DENTIST PHONE NO.	28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) 29. DATE OF PRIOR PLACEMENT
23. FIRST VISIT DATE — 24. RADIOGRAPHICS OR MODELS ENCLOSED? NO ☐ YES ☐ HOW MANY?	30. IS TREATMENT FOR ORTHODONTICS?			

IDENTIFY MISSING TEETH WITH "X"



32. REMARKS FOR UNUSUAL SERVICES ON REVERSE SIDE CHECK ☐

31. EXAMINATION AND TREATMENT PLAN: LIST IN ORDER FROM TOOTH NO. 1 THROUGH NO. 32 — USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING XRAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO. DAY YEAR	PROCEDURE NUMBER	FEE

FOR ADMINISTRATIVE USE ONLY

CHECK ONLY ONE

33. ☐ DENTIST'S TREATMENT PLAN (PRE-DETERMINATION OF BENEFITS).

34. ☐ DENTIST'S STATEMENT OF ACTUAL SERVICES:

I Hereby Certify That The Above Procedures Were Rendered On The Dates Indicated

35. _____ Signed (Dentist) _____ Date

TOTAL FEE CHARGED

I AM A SPECIALIST IN: ☐ ORAL SURGERY ☐ ORTHODONTICS ☐ PERIODONTICS ☐ ENDODONTICS ☐ OTHER

REMARKS

36. ☐ I AM ☐ I AM NOT A PARTICIPATING DENTIST

37. TO BE COMPLETED BY PARTICIPATING DENTISTS ONLY
☐ I HAVE BEEN PAID ☐ YES ☐ NO IF "YES" AMOUNT PAID $ _____
☐ I WAS NOTIFIED BEFORE SERVICES WERE RENDERED THAT SEBF INSURES THE PATIENT

SERVICE EMPLOYEES BENEFIT FUND

P.O. Box 1600
Syracuse, New York 13201

SERVICE EMPLOYEES BENEFIT FUND

A. CLAIMS FILING INSTRUCTIONS — Follow these instructions to avoid delay.

Mail the CLAIM FORM promptly to:

Service Employees Benefit Fund
P.O. Box 1600
Syracuse, New York 13201

1. Complete items 1 through 17 in full to assure positive identification and prompt payment.
2. The Employee must sign and date the claim form.
3. All claim forms must be submitted to Service Employees Benefit Fund within 90 days of commencement of services or 30 days after the services are completed, whichever is sooner.
4. If you use a Participating Dentist, payment will be made directly to the dentist.
5. Dental coverage is subject to specific limitations and exclusions according to the Service Employees Benefit Fund Schedule of Benefits.
6. This form will be returned to the employee if it is incomplete or incorrect.

INSTRUCTIONS FOR DENTIST:

1. Service Employees Benefit Fund will pay benefits according to its Schedule of Benefits. A separate fee is required for each service.
2. Participating Dentists: To determine what benefits apply to your patient, refer to the Service Employees Benefit Fund Schedule of Benefits or call the Fund Office at (315) 424-1754 or (800) 733-1754.

B. TO BE COMPLETED FOR DEPENDENT STUDENTS AGE 19 AND OVER

Please submit proof of current semester full-time student status from school's Bursar or Registrar's Office. If proof of current semester full-time student status has already been submitted, it is not necessary to resubmit.

I certify that my dependent _____ meets all requirements for eligibility as a dependent student and was eligible during the entire period covered by this claim.

I expect eligibility to continue until the date of _____

Name of School _____ City _____

Date Started _____ Graduates _____

Has dependent had military service? ☐ Yes ☐ No If Yes, give dates of service _____

Employee's Signature _____ Date _____

C. DISABLED DEPENDENT OVER AGE 19

If dependent over age 19 is disabled and eligibility has not been established, contact the **Service Employees Benefit Fund** at: **(315) 424-1754** or **(800) 733-1754**.

PRESENTATION OF FALSE PROOF IN SUPPORT OF A CLAIM ON A POLICY OF INSURANCE IS UNLAWFUL UNDER SECTION 175.50 OF THE PENAL CODE