

NOTICE TO MEMBERS

- **THERE IS A \$2,000 YEARLY DENTAL PLAN MAXIMUM PER COVERED PERSON PER PLAN YEAR (JAN. 1 THROUGH DEC. 31).**
- **PRE-TREATMENT REVIEW BY THE FUND'S DENTAL CONSULTANT IS REQUIRED FOR ANY PROPOSED COURSE OF TREATMENT IN WHICH A DENTIST'S CHARGES WILL AMOUNT TO \$500 OR MORE. X-RAYS MUST BE INCLUDED WITH TREATMENT PROGRAMS SUBMITTED FOR PRE-TREATMENT REVIEW. Pre-Treatment Review by the Fund's Dental Consultant is limited to the review of the course of treatment proposed; it does not include approval of payment for services not covered under the Dental Plan, or of the fees charged by non-participating dentists.**

POST-TREATMENT REVIEW

- **Completed treatment amounting to \$1,000 or more requires examination of patient by Fund's Consultant Dentist before payment is made.**
- **CLAIM MUST BE SUBMITTED WITHIN ONE YEAR AFTER COMPLETION OF COURSE OF DENTAL TREATMENT.**
- **Bring a claim form with you when you visit your dentist. Complete your part, give all the information required. DISCUSS FEES BEFORE SERVICES ARE PERFORMED. If you have any questions about your benefits, contact the Fund office.**
- **Participating Dentists have agreed to accept payment directly from the Welfare Fund, and there is no out-of-pocket expense to the patient for COVERED services up to the \$2,000 yearly maximum. You may obtain the names and addresses of Participating Dentists located conveniently to your home or work location from the Fund Office. This is an information service for covered members and eligible dependents: *The Fund does not recommend the services of any particular dentist.***
- **Non-participating dentists have no agreement with the Fund and must be paid by the member or covered patient. The member must file a claim with the Fund for reimbursement, and payment will be made only to the member in accordance with the Fund's Schedule of Dental Benefits.**
- **If claim is for dependent student over age 19, attach proof of school attendance.**
- **PLEASE MAKE SURE YOU HAVE SIGNED THE DENTAL PROCEDURE CERTIFICATION BOX ON THE BOTTOM OF THE CLAIM FORM.**

- Mail this form to:
**SOCIAL SERVICE EMPLOYEES UNION
LOCAL 371 BENEFITS FUND**
1501 Broadway, Suite 450 • New York, NY 10036
Tel: (212) 777-9000, Ext. 3506

NOTICE TO DENTISTS

- **Please note that copies of signatures and "signatures on file" will not be accepted as valid by the Fund office and the claim form will be returned to you.**

FUND'S DENTAL CONSULTANT REMARKS

ANYONE INTENTIONALLY MISUSING THIS FORM FOR THE PURPOSE OF OBTAINING IMPROPER PAYMENTS IS SUBJECT TO APPROPRIATE ACTION