IMPORTANT NOTICE

PRE-AUTHORIZATION REQUIRED FOR $500 OR MORE

X-RAYS MUST BE ATTACHED IF CLAIM IS $500 OR MORE

SEE INSTRUCTIONS ON REVERSE SIDE

MAIL COMPLETED FORM TO:

Manhasset Education Association Trust Fund
253 WEST 35TH STREET, 12TH FLOOR
NEW YORK,NEW YORK 10001-1907
(212) 505-5050

MANHASSET EDUCATION ASSOCIATION — MAKING EXCELLENCE ACHIEVABLE — TEACHERS

MEMBER

PATIENT NAME: (print last name first)	SEX ☐ M ☐ F	RELATIONSHIP TO MEMBER ☐ Self ☐ Child ☐ Spouse ☐ Other	PATIENT DATE OF BIRTH MO. DY. YR.
MEMBER NAME: (print last name first)	SEX ☐ M ☐ F	SOCIAL SECURITY NO.	Is this the first dental claim filed by you? ☐ YES ☐ NO
HOME ADDRESS: (Include Zip Code)	APT.	HOME PHONE (include area code)	
MEMBER'S SCHOOL	Is your mailing address different from last claim filed? ☐ YES ☐ NO	OFFICE PHONE (include area code)	

IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO — IF "YES" GIVE NAME AND ADDRESS OF YOUR SPOUSE'S EMPLOYER AND SPOUSE'S SOCIAL SECURITY #

ARE DENTAL BENEFITS AVAILABLE FROM ANY OTHER CARRIER FOR THIS PATIENT? ☐ YES ☐ NO — IF "YES" GIVE NAME OF CARRIER AND I.D. NO. OF SUBSCRIBER

IF YES, SPOUSE BIRTHDATE _____ MONTH _____ DAY _____

To be signed if Benefits are to be paid directly to your doctor.

ASSIGNMENT OF BENEFITS:

I hereby assign to Dr. _____ the benefits I am entitled to as represented by this claim. I understand that I am financially responsible for charges not covered and/or paid by this assignment.

Signature of Member _____ Date _____

MEMBERSHIP CERTIFICATION:

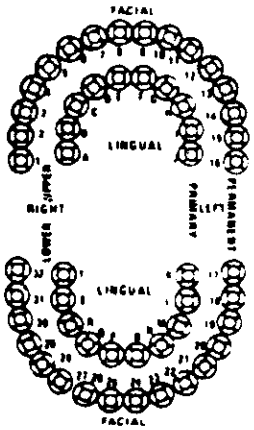
I certify that the information given is correct and authorize release of any information necessary to process this claim.

Signature of Member _____ Date _____

DENTIST

DENTIST NAME	IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
MAILING ADDRESS	IS TREATMENT RESULT OF AUTO ACCIDENT?			
	OTHER ACCIDENT?			
CITY, STATE, ZIP	ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
DENTIST SOC. SEC. or T.I.N. DENTIST LICENSE NO. DENTIST PHONE NO.	IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) DATE OF PRIOR EMPLOYMENT
FIRST VISIT DATE PLACE OF TREATMENT RADIOGRAPHICS CURRENT SERIES Office Hosp. ECF Other OR MODELS YES NO HOW MANY?	IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER: DATE APPLIANCES PLACED MOS. TREATMENT REMAINING

Indicate missing teeth with 'X'



REMARKS FOR UNUSUAL SERVICES OR ATTACHMENT CHECK ☐

USE CHARTING SYSTEM AT LEFT. DESCRIBE YOUR TREATMENT PLAN OR SERVICES COMPLETED.

Tooth or Letter	Surface	DESCRIPTION OF SERVICE (including X-RAYS, PROPHYLAXIS, MATERIALS USED, etc.) LINE NO.	Date Service Performed	CDT Procedure Number	FEE	OFF. USE

— CHECK ONE ONLY —

☐ **DENTIST'S TREATMENT PLAN (PRE-AUTHORIZATION):**
I hereby certify that the above procedures are necessary to be performed.

Dentist's Signature _____ Date _____

☐ **DENTIST'S STATEMENT OF ACTUAL SERVICES:**
I hereby certify that the above procedures were rendered on the dates indicated.

Dentist's Signature _____ Date _____

TOTAL FEE CHARGED

I am a specialist in:
☐ Orthodontics ☐ Oral Surgery
☐ Endodontics ☐ Periodontics
☐ Other

MEMBER

I certify that to the best of my knowledge the dental procedures listed above were actually performed and the dates on which they performed are accurate. Signature _____ Date _____

PLEASE NOTE THAT THIS MUST BE SIGNED BY THE MEMBER/PATIENT IN ORDER FOR THIS CLAIM TO BE PROCESSED.

THIS FORM MAY HAVE TO BE RETURNED IF IT IS INCOMPLETE OR INCORRECT

NOTICE TO MEMBERS

- THERE IS A $2000 YEARLY DENTAL PLAN MAXIMUM PER COVERED PERSON PER CALENDAR YEAR.
- PRE-AUTHORIZATION BY THE FUND'S DENTAL CONSULTANT IS REQUIRED FOR ANY PROPOSED COURSE OF TREATMENT IN WHICH A DENTIST CHARGES WILL AMOUNT TO $500 OR MORE. ALL PROSTHETIC SERVICES MUST BE PRE-AUTHORIZED, whether or not the charges will amount to $500 or more. X-RAYS MUST BE INCLUDED WITH TREATMENT PROGRAMS SUBMITTED FOR PRE-AUTHORIZATION. Pre-authorization by the Fund's Dental Consultant is limited to the approval 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. Completed treatment amounting to $1,000 or more may require examination of patient by Fund's Consultant Dentist before payment is made.
- CLAIM MUST BE SUBMITTED WITHIN 90 DAYS 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.
- PLEASE MAKE SURE YOU HAVE SIGNED THE DENTAL PROCEDURE CERTIFICATION BOX ON THE BOTTOM OF THE CLAIM FORM.
- Mail this form to: Manhasset Education Association Trust Fund
  253 WEST 35TH STREET, 12TH FLOOR
  NEW YORK,NEW YORK 10001-1907 Telephone (212) 505-5050

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.
- PRE-AUTHORIZATION BY THE FUND'S DENTAL CONSULTANT IS REQUIRED FOR ANY PROPOSED COURSE OF TREATMENT IN WHICH A DENTIST CHARGES WILL AMOUNT TO $500 OR MORE. ALL PROSTHETIC SERVICES MUST BE PRE-AUTHORIZED, whether or not the charges will amount to $500 or more. X-RAYS MUST BE INCLUDED WITH TREATMENT PROGRAMS SUBMITTED FOR PRE-AUTHORIZATION. Pre-authorization by the Fund's Dental Consultant is limited to the approval 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. Completed treatment amounting to $1,000 or more may require examination of patient by Fund's Consultant Dentist before payment is made.

FUND'S DENTAL CONSULTANT REMARKS:

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