PSC CUNY Welfare Fund
61 Broadway, 15th Floor
New York, NY 10006
Phone: 212-354-5230 Fax: 212-354-5363

Direct Dental Reimbursement Form

For Plan 70 Retirees

File within 90 Days of Service

Member

Last Name _____ **First Name** _____

Street Address _____

City _____ **State** _____ **Zip Code** _____

Social Security Number _____

Employer - College (prior to retirement) _____

Member Status: ☐ Retired ☐ COBRA ☐ Survivor

Patient

Relationship to Member ☐ Self ☐ Spouse / Domestic Partner ☐ Dependent Child

Complete the following only if the Patient is <u>not</u> the Member :

Name of Patient _____

Other Dental Coverage: Name of Employer or Union _____ Contact _____

Amount Requested

$ _____

Note the maximum annual reimbursement is $300 ***per family*** .

Enclose an original bill from the dental provider with the following information;

- Retiree name and address
- Patient's name and relationship to Retiree
- Dental Service provided - including Procedure code
- Date of Service
- Amount due for services

I hereby certify that the above is true and accurate to the best of my knowledge.

Signature of Member _____ **Date** _____

Signature of Provider _____ **Date** _____

OFFICE USE ONLY : Check # _____ Check Date _____ Amt. _____ *Approved* _____