PSC CUNY Welfare Fund
P.O. Box 280278
Brooklyn, NY 11228
Phone: 212-354-5230 www.psccunywf.org

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 not 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* ____________