



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

Direct Dental Reimbursement Form
For Plan 80 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:	<input type="checkbox"/> Retired <input type="checkbox"/> COBRA <input type="checkbox"/> Survivor

Patient	
Relationship to Member	<input type="checkbox"/> Self <input type="checkbox"/> Spouse / Domestic Partner <input type="checkbox"/> Dependent Child
<i>Complete the following only if the Patient is not the Member :</i>	
Name of Patient _____	
Other Dental Coverage:	Name of Employer or Union _____ Contact _____

Amount Requested	\$ _____
Note the maximum annual reimbursement is \$150 <i>per family</i> .	

Enclose an original bill from the dental provider with the following information;
<ul style="list-style-type: none">• 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 _____
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