342 INSURANCE TRUST
CLAIM FOR DENTAL BENEFITS

Please return this form to:
342 INSURANCE TRUST
501 William Floyd Parkway
Shirley, N.Y. 11967-3417
Tel. 631-395-1700
Fax: 631-395-1943

PART 1 - TO BE COMPLETED BY EMPLOYEE

1. Patient Name
2. Relationship to employee: Self | Spouse | Child | Other
3. Sex: M | F
4. Patient Birthdate: Mo. | Day | Year
5. If full time student: School | City

6. Employee Name: First | Middle | Last
7. Employee Social Security No. ___ ___ ___ — ___ ___ — ___ ___ ___ ___

8. Employee Mailing Address
9. Is This Addres ☐ New ☐ Temporary

10. Employer's Name
11. Employer's Address | City | State | Zip

12. Is spouse or other family member employed? ☐ Yes ☐ No
If yes, Member's Name | Soc. Sec. No.
13. Name and Address of Employer in Item 12.
14. Spouse Birthdate: Mo. | Day | Year

15. Is Patient Covered by another Dental Plan ☐ Yes ☐ No If yes, Dental Plan name | Group No. | Name and Address of Carrier

CERTIFICATION — I certify that the foregoing information is true and correct.

EMPLOYEE'S SIGNATURE ______ DATE ______ **OR** ______ DEPENDENT PATIENT'S SIGNATURE - IF NOT A MINOR

AUTHORIZATION TO RELEASE INFORMATION — I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, treatment, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable. This authorization or a copy shall be valid for one year from the date of signature.

SIGNED (PATIENT OR PARENT IF MINOR) ______ DATE ______

AUTHORIZATION TO PAY BENEFITS TO PROVIDER - I hereby authorize payment directly to the below named Dentist of the Dental Benefits otherwise payable to me.

SIGNED (EMPLOYEE) ______ **DATE** ______

PART II - TO BE COMPLETED BY ATTENDING DENTIST

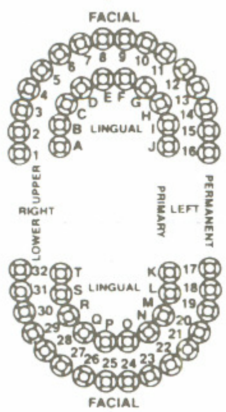
16. Dentist Name
17. Mailing Address
City, State, Zip
18. Tax I.D. # To Be Used For Tax Reporting | Tax I.D. # | Soc. Sec. #
19. Dentist License No.
20. Dentist Phone No.
21. First visit date current series
22. Place of treatment: Office | Hosp | ECF | Other
23. Radiogram or Model enclosed? No | Yes | How Many

	No	Yes	
24. Is treatment result of occupational illness or injury?			If Yes, Enter Brief Description and Dates
25. Is treatment result of Auto Accident? 26. Other Accident?			
27. Are any services covered by another plan?			If Yes, name of other plan
28. If Prosthesis, is this initial placement?			(If no, reason for replacement) 29. Date of prior placement
30. Is treatment for Orthodontics?			If services already commenced, enter: Date appliances placed; Mos. treatment remaining

☐ Predetermination of Benefits
☐ Statement of Actual Services

31. Examination and treatment plan — list in order form tooth No. 1 through tooth No. 32 — use charting shown.

Indicate missing teeth with an "X"



Tooth # or Letter	Surface (i.e., M,O,D,B,L,LA,1)	DESCRIPTION OF SERVICE (including X-rays,prophylaxis, materials used, etc.)	Date Service Completed Mo	Day	Year	Procedure Number	FEE

32. Remarks for unusual services

I hereby certify that the procedures as indicated by date have been completed and the fees indicated are those actually charged the patient regardless of the existence of insurance coverage.

TOTAL FEE CHARGED ______

SIGNED (Dentist) ______ Date ______

PART III - TO BE COMPLETED BY 342 INSURANCE TRUST

CURRENT YEAR DEDUCTIBLE	PREVIOUS YEAR DEDUCTIBLE	CLAIM BRANCH NO.	WORKER'S COMP. ☐ YES ☐ NO	WORK RELATED ILLNESS/INJURY ☐ YES ☐ NO

1/1/92

Any person who knowingly and with intent to defraud that files a statement containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

INSTRUCTIONS

FOR THE EMPLOYEE

1. Please answer all questions in Part 1 entitled "TO BE COMPLETED BY EMPLOYEE".
2. Sign and Date the "Authorization to Release Information".
3. If you wish to have your benefits paid directly to the Dentist, sign and date the "Authorization to pay Benefits to Dentist".

   If authorized, payment will be made directly to your Dentist. A copy of the payment will be sent to you for your records. Otherwise, payment will be made directly to you.

FOR THE DENTIST

For claims involving Predetermination of Benefits:

1. Complete the section "TO BE COMPLETED BY ATTENDING DENTIST". Be sure to itemize charges for each proposed procedure.
2. 342 Insurance Trust will review the treatment plan and will provide the estimate of benefits payable.
3. Review the form and benefit estimates with your patient before the work is done.
4. When you complete treatment, return the form with the treatment dates completed and your signature.

For claims not involving Predetermination of Benefits:

1. Complete Part II. Be sure to date and itemize charges.
2. Sign and date bottom of claim form when work is completed.

PLEASE NOTE: IF THE CLAIM FORM IS NOT COMPLETED IN FULL AND SERVICES ARE NOT COMPLETELY ITEMIZED, PROCESSING OF PAYMENT WILL BE DELAYED UNTIL ALL REQUIRED INFORMATION HAS BEEN SUBMITTED.

The following supportive documentation, as indicated below, may be necessary to determine benefits:

A. Pre-operative X-rays and/or Narrative

- Gold Inlay Restorations
- Crowns - Single Restorations
- Root Canal Therapy
- Dentures - Partial
- Bridges - Pontics, Abutments, and Inlays
- Oral Surgery

B. Periodontal Case Type and Pocket Depth Chart

- Scaling and Root Planing
- Gingivectomy/Gingivoplasty
- Curettage
- Periodontal Surgery - Osseous, Mucogingival

C. Narrative

- Space Maintainers
- Dentures - Full
- Alveoloplasty
- Grafts
- Anesthesia

COMMENTS