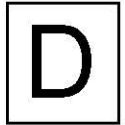


# YORKTOWN CONGRESS OF TEACHERS WELFARE FUND

2729 Crompond Road  
Yorktown Heights, NY 10598  
914-962-7442



## DENTAL BENEFIT

STATEMENT OF CLAIM FOR THE YEAR 20\_\_\_\_\_

To receive your dental benefit for the member or eligible dependent, you must submit a copy of the bill indicating the **patient's name, date of service and charges including appropriate ADA codes**. It must be signed by a licensed dentist. Payment will be based on the current schedule of dental benefits. This benefit may be subject to a deductible.

NO PAYMENTS WILL BE MADE FOR ANY REASON **90** DAYS AFTER  
THE YEAR IN WHICH SUCH DENTAL EXPENSES WERE INCURRED.

### MEMBER MUST COMPLETE THIS SECTION

PATIENT IS:  EMPLOYEE  SPOUSE  DEPENDENT CHILD

NAME OF MEMBER \_\_\_\_\_

BUILDING ASSIGNMENT \_\_\_\_\_

JOB CATEGORY \_\_\_\_\_

AMOUNT CLAIMED \_\_\_\_\_

I understand that I am responsible for any expense not covered by this benefit.

Date: \_\_\_\_\_ Member's Signature: \_\_\_\_\_

Retirees, please provide current address that you want benefit mailed to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### FOR TRUSTEES ONLY

DATE OF PAYMENT \_\_\_\_\_

CHECK# \_\_\_\_\_

AMOUNT PAID \_\_\_\_\_

CLAIMS MAY BE SENT VIA INTERSCHOOL MAIL TO YCT WELFARE FUND IN BUILDING **B**