CLAIM FORM FOR DENTAL BENEFITS

WHEN COMPLETE

RETURN FORM TO:

AGVA WELFARE TRUST FUND
363 Seventh Avenue – 17th Floor
New York, New York 10001-3904
(212) 627-4820

TO BE COMPLETED BY PERFORMER:

LAST NAME________________________________FIRST NAME, MI________________________________

ADDRESS________________________________CITY________________________STATE_____ZIP CODE________

DATE OF BIRTH (mm/dd/yyyy)_____/_____/_______ SEX (circle to indicate) Female Male S.S. # ___-__-____

PHONE (_____)_______-__________CELL(_____)_______-__________EMAIL ADDRESS________________________

MOST RECENT AGVA PERFORMANCE – Group, Venue & DATE OF SHOW:________________________________

OTHER HEALTH CARE INSURANCE (name of plan, address, policy & group #s)________________________

PLEASE SIGN WHERE INDICATED BELOW: I hereby authorize my provider to release information, as necessary, to AGVA Welfare Trust Fund in order to process this claim. I hereby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse The AGVA Welfare Trust Fund to the extent of any overpayment which is in excess of the amounts payable under the benefit plan.

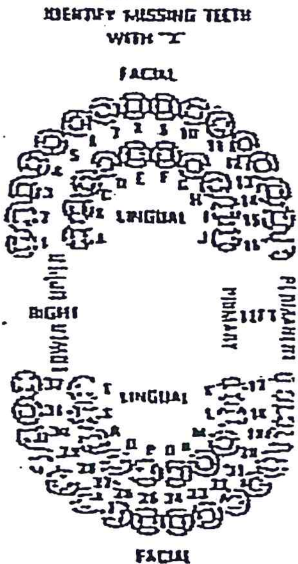
SIGN HERE (*for ALL claims*): ____DATE__________
Sign here to pay provider ____DATE__________
Sign here to pay insured ____DATE__________

TO BE COMPLETED BY DENTIST:

DENTIST NAME________________________________S.S. or T.I.N. #________________LICENSE #__________

ADDRESS____PHONE________________

FIRST VISIT DATE__________COVERED UNDER ANOTHER PLAN? ____ IF PROSTHESIS, IS THIS INITIAL PLACEMENT?____IF NO, REASON FOR PLACEMENT (EXPLAIN ON REVERSE & GIVE DATE OF PRIOR PLACEMENT); IS TREATMENT FOR ORTHODONTICS?____
IS TREATMENT RELATED TO: ILLNESS OR INJURY?_____ AUTO ACCIDENT?____ IF YES, PROVIDE DATES AND DESCRIPTION ON REVERSE
CHECK ONE: ____DENTIST STATEMENT OF ACTUAL CHARGES ____DENTIST'S PRE-TREATMENT ESTIMATE OF CHARGES



Tooth #	surface	Description of service including x-rays, Prophylaxis, materials used, etc.	date	Procedure number	Fee

DENTIST CERTIFICATION FOR SERVICES PROVIDED:

I certify that the above number of ______ items were provided and completed by me.

Dentist's Signature________________________________**Date**__________

TOTAL FEE CHARGED ____________

MAXIMUM ALLOWABLE____________

C.O.B. ____________

TOTAL BENEFIT ____________

DENTAL INFORMATION – Covered expenses on "Total Benefits" are authorized. Payment will be made provided treatment is performed while the patient is covered. Payment will be made subject to all limitations and maximums.

NOT TO BE SIGNED BY PERFORMER UNTIL WORK IS COMPLETED. I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE