HARRISON CSEA BENEFITS FUND

c/o Insurance Programmers, Inc.
PO BOX 5817
Wallingford, CT 06492-7616
Tel: 1-800-827-1703 Fax: 1-203-284-8656

DENTAL CLAIM FORM

(this section to be completed by employee)

1. Employee's Name	**2. Social Security No**	**Employee's Birthdate**
4. Employee's Mailing Address (City) (State) (Zip)		**5. Tel No.**
6. Patient's Name (If a dependent)	**7. Relationship to Employee**	**8. Patient's Birth Date**
9. Date First Visit (Current Series	**10. Patient's Social Security No.**	**11. Does Patient have other dental coverage? [ ] YES [ ] NO**

TO BE COMPLETED BY DENTIST

IF CLAIM IS BASED ON ACCIDENT:

WHEN DID ACCIDENT OCCUR? DATE _____ TIME _____

WHERE DID ACCIDENT OCCUR? _____

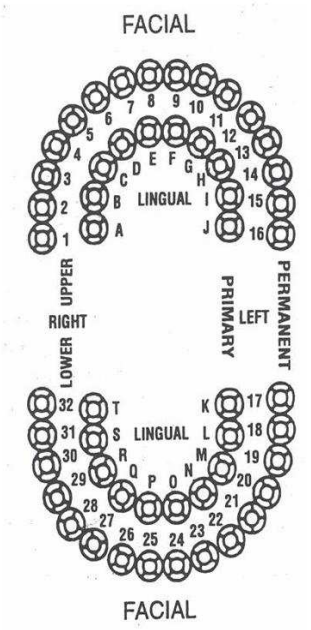
HOW DID IT HAPPEN? _____

CHECK ONE: [ ] DENTIST'S PRE-STATEMENT ESTIMATE
[ ] DENTIST'S STATEMENT OF ACTUAL SERVICE

If Charges will be for $500.00 or more, this form must be submitted for pre-determination of benefits. After review by the Fund Office, the member and the dentist will be notified of the estimated payment.

Dentist's Name (Print)	Telephone No.	Individual Practitioner's – SS No.	
Address City State or Province Zip		All Others – Employer I.D. No.	

Is any of the treatment for Orthodontic purposes [ ] YES [ ] NO	IF PROSTHEISS, IS THIS INITIAL PLACEMENT? [ ]YES [ ]NO IF NO, REASON FOR PLACEMENT:	DATE OF PRIOR PLACEMENT:
X-Rays are required for extraction of impacted teeth, gold restorations, crowns or bridge work and may also be requested for other services. X-Rays will be returned to Dentist promptly.		Are X-Rays enclosed? [ ] YES [ ]NO If YES, How Many?



EXAMINATIONS AND TREATMENT RECORD – USE CHARTING SYSTEM SHOWN

TOOTH No. OR LETTER	NAME OF SURFACES ABBR.	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	ADA PROCEDURE NUMBER	DATE SERVICE PERFORMED MO	DA	YR	FEE	FOR CARRIER USE ONLY
				TOTAL FEE ACTUALLY CHARGED				

Indicate missing teeth with an "X"
Remarks for unusual services

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM:

_____

DATE: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize payment directly to the above physician for vision benefits otherwise payable to me for his services described on this form, but not to exceed the reasonable IGNED (Patient or Parent if minor) and customary fee for the service.

_____

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED: _____ DATE: _____
Signature of Dentist