NEW YORK STATE
SUPREME COURT OFFICERS ASSOCIATION
SECURITY BENEFIT FUND
DENTAL EXPENSE CLAIM

WHEN THIS FORM IS COMPLETED BY YOUR DENTIST AND BY YOU, RETURN IT TO:

MALONEY ASSOCIATES, INC.
P.O. BOX 7017
LYNBROOK, N.Y. 11563

MEMBER'S STATEMENT (Print or Type)

MEMBER'S NAME (LAST, FIRST, MIDDLE INITIALS)	MEMBER'S SOC. SEC. NO.	IF PATIENT HAS OTHER DENTAL COVERAGE GIVE NAME OF PLAN
MEMBER'S ADDRESS (NUMBER, STREET)	PATIENT'S NAME (LAST, FIRST, MIDDLE INITIALS)	PATIENT'S DATE OF BIRTH
CITY, STATE, ZIP CODE	PATIENT'S RELATIONSHIP TO MEMBER ☐ SELF ☐ SPSE ☐ DGTR ☐ SON ☐ _____	IS TREATMENT RESULT OF ACCIDENT? ☐ YES ☐ NO — WORKER'S COMP. ☐ NO ☐ YES ☐ POSSIBLE

I Hereby Certify That The Above Statements Are Correct And Authorize Release of Any Information Relating to This Claim.

Date _____ Member's Signature _____

ATTENDING DENTIST'S STATEMENT

DENTIST NAME FIRST MIDDLE LAST			IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES
MAILING ADDRESS			IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?		
CITY, STATE		ZIP	ARE ANY SERVICES COVERED BY ANOTHER PLAN?		
DENTIST SOC. SEC. OR T.I.N	DENTIST LICENSE NO	DENTIST PHONE NO.	IF PROSTHESIS, IS THIS INITIAL PLACEMENT?		
FIRST VISIT DATE CURRENT SERIES	PLACE OF TREATMENT: OFFICE / HOSP. / ECF / OTHER	RADIOGRAPHS OR MODELS ENCLOSED? NO / YES / HOW MANY?	IS TREATMENT FOR ORTHODONTICS?		

IF YES, ENTER BRIEF DESCRIPTION AND DATES

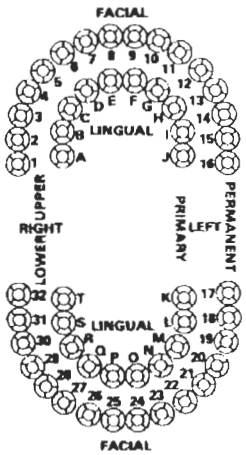
IF YES, NAME OF OTHER PLAN

(IF NO, REASON FOR REPLACEMENT) DATE OF PRIOR PLACEMENT

IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED MOS. TREATMENT REMAINING

DENTIST — CHECK ONE
☐ PRETREATMENT ESTIMATE
☐ STATEMENT OF ACTUAL SERVICES

IDENTIFY MISSING TEETH WITH "X"



REMARKS FOR UNUSUAL SERVICES

EXAMINATION AND TREATMENT PLAN — LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32
USE CHARTING SYSTEM SHOWN

Tooth No. or Ltr.	Surface	DESCRIPTION OF SERVICES (Including X-Rays, Prophylaxis, Materials Used, etc.)	Date Service Performed Mo.	Day	Yr	Procedure Number	FEE	ADMINISTRATIVE USE ONLY Eligible Amount