Sun Life Financial®

Sun Life and Health Insurance Company (U.S.)
Group Dental Benefits
P.O. Box 81633
Wellesley Hills, Ma 02481
ebg.sunlife.com

DENTAL CLAIM STATEMENT
NEW YORK STATE SCHOOL TRUST

Helpful information about filing for benefits is included on the reverse side. For further assistance, call 1-(800)-321-1336.

Part I - Employee's Statement - Please Print

Name of Employee (Last, First, M.I.)	EE Social Security Number - -	Date of Birth / /	Sex ☐ Male ☐ Female	Group Account Number 500
Employee's Complete Home Mailing Address (No., Street, City, State, Zip)			Employer's Name Huntington U.F.S.D.	

Is spouse employed? ☐ Yes ☐ No	Spouse's Name	Spouse's Date of Birth / /	Spouse's Social Security Number - -

Name of Patient (Last, first, middle initial)	Date of Birth / /	Relationship to Employee	Does employee have custody? ☐ Yes ☐ No	Patient's Social Security Number - -

Is patient covered by any other dental plan? ☐ Yes ☐ No	If Yes, Give Name of Carrier	Subscriber's Name and Relationship to Patient	Group Number	Check One ☐ Family ☐ Single

Is dependent (19 yrs. or older) a full-time student? ☐ Yes ☐ No	If Yes, School Name and City	Expected Date of Graduation

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the provider named below on this claim for the group dental benefits otherwise payable to me, but not to exceed the charges shown. I understand that I am financially responsible for any charges not covered by this authorization.	Signature of Employee	Date

I authorize the release and disclosure of my protected health information and other information as described below.

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any health care provider or health care facility to disclose or furnish to Sun Life and Health Insurance Company (U.S.) (SLHIC (U.S.)) including any legal representatives designated by SLHIC (U.S.), the following protected health information: Dental or Medical records or other information of a medical nature in regard to my physical or mental condition or the physical or mental condition of my dependents. This authorization extends to and includes HIV-related information, AIDS or AIDS related disorders or information relating to alcohol or drug abuse treatment or services or mental health care to the extent permitted by law.

I further authorize any employer to which this authorization is directed to disclose or furnish my employment, financial and wage information to SLHIC (U.S.) and any legal representative that it might designate.

I authorize SLHIC (U.S.) to use or disclose this protected health care information, in connection with payment or health care operations, to any person or entity performing a business or legal function on behalf of SLHIC (U.S.) or as otherwise specifically permitted or required by law. I understand that information disclosed to, or by, SLHIC (U.S.) pursuant to this authorization might be subject to re-disclosure and no longer protected by the HIPAA Privacy Rule.

I understand that: (1) the protected health information being released will be used for the purpose of evaluating a claim for insurance benefits; (2) my refusal to sign this authorization may adversely affect the payment of claims; (3) I have the right to revoke this authorization at any time by writing to SLHIC (U.S.) at the address listed at the top of this form; and (4) I am entitled to a photocopy of this authorization upon request.

This authorization is valid for up to 12 months from the date it was signed. Revocation of this authorization will not affect the rights of any person or entity who acted in reasonable reliance on the authorization before receiving notice of the revocation. A photocopy of this authorization shall be as valid as the original.

Signature of Employee	Date	Signature of Dependent Patient (Parent should sign for minor child)	Date

WARNING
STATE LAW IN SOME STATES REQUIRES THE FOLLOWING STATEMENT:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto (in Oregon, "may be guilty of insurance fraud,") commits a fraudulent insurance act, which (in Oregon "may be subject to prosecution.") is a crime and subjects such person to criminal and civil penalties.

THIS NOTICE DOES NOT APPLY IN VIRGINIA.

IN CALIFORNIA: "Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

IN FLORIDA: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree."

IN LOUISIANA: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

IN NEW JERSEY: "Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

IN NEW YORK: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and shall be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation."

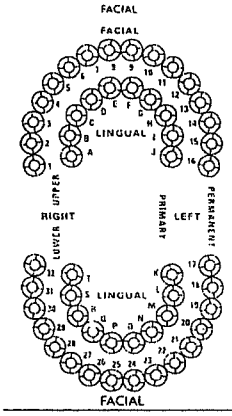
IN PUERTO RICO: "Any person who, knowingly and with the intent to defraud, presents false information in an insurance request for, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or present more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than $5,000 nor more than $10,000, or imprisonment for a fixed term of 3 years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of 5 years; if attenuating circumstances prevail, it may be reduced to a minimum of 2 years."

See Reverse Side

Part II - Attending Dentist's Statement - Please Print

Name of Dentist (First, Last)	Dentist's Telephone Number	Name of Patient (Last, First, M.I.)	Is dentist related to patient by blood or marriage? ☐ Yes ☐ No Relationship _____
Dentist's Office Location (No., Street, City, State, ZIP Code)		Orthodontic Treatment ➤ Date Appliance Inserted	Expected Treatment Duration: _____ Months / Class of Malocclusion ☐ I ☐ II ☐ III
Dentist's Tax I.D.	Dentist's License Number	Is treatment the result of an accident? ☐ Yes ☐ No If Yes ☐ Occupational ☐ Auto ☐ Other / For crown, bridge or other prosthesis is this initial placement? ☐ Yes ☐ No	If not, date of prior placement. Mo. _____ Year _____
Remarks		Prior partial? ☐ Yes ☐ No / If No, Date of Extractions / Teeth Involved in Prior Prosthesis	
		Final Prep Date _____ Impression Date _____ Seat Date _____	

IDENTIFY MISSING TEETH WITH AN "X" FOR ALL SUBMISSIONS



Examination and Treatment Plan- List in order from tooth No. 1-32 (Use Chart System Shown)

Tooth Number or Letter	Surface	Description of Service (including X-rays, prophylaxis, materials, etc.) Line No.	Date Service Performed MM DD YY	Procedure Number	Fee	For Administrative Use Only

Radiographs or Image Enclosed ☐ Yes ☐ No

Dentist's Signature _____ Date _____

I hereby certify that the procedures as Indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

PREDETERMINATION OF BENEFITS DOES NOT GUARANTEE PAYMENT - Recommended for charges of $500.00 or more. Predetermination of your claim advises you in advance of the amount of benefits payable if described procedures are performed during a period of patient's eligibility. Benefits payable are subject to COB and other policy provisions.

How to File Your Claim

1. Complete Part I - Employee's Statement.
2. Have your Dentist complete Part II - Attending Dentist's Statement.
3. Be sure form is completed. Mail completed form to address shown below.

Mail Completed Claim To:

Sun Life and Health Insurance Company (U.S.)
Employee Benefits Group
Dental Benefits
PO Box 81633
Wellesley Hills, MA 02481

If you have any questions, please contact 1-800-321-1336, 516-777-2244.

Sun Life and Health Insurance Company (U.S.) is a member of the Sun Life Financial group of companies.