

WHEN COMPLETE
RETURN FORM TO:

CLAIM FORM FOR DENTAL BENEFITS
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:

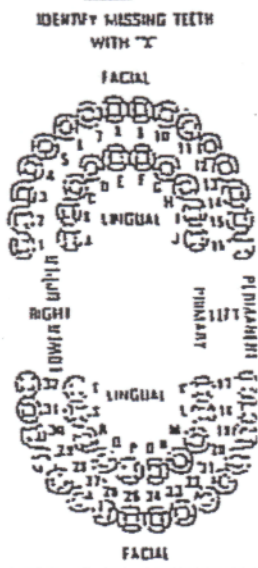
DENTIST NAME _____ S.S. or T.I.N. # _____ LICENSE # _____

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.

TOTAL FEE CHARGED _____

Dentist's Signature _____ Date _____

MAXIMUM ALLOWABLE _____

C.O.B. _____

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.

TOTAL BENEFIT _____

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