Social Security or AID No. _____

DENTAL

GSA-ILA EMPLOYERS WELFARE FUND
SUPPLEMENTAL DENTAL CLAIM FORM

ATTENDING DENTIST

ATTENDING DENTIST: IF YOU ARE FILING DENTAL CLAIMS WITH THE GSA-ILA EMPLOYERS WELFARE FUND ON FORMS PROVIDED BY THE AMERICAN DENTAL ASSOCIATION, YOUR CLAIM IS NOT COMPLETE UNTIL THIS FORM IS COMPLETED, SIGNED, AND RETURNED TO THE FUND OFFICE.

SECTION A. PATIENT AND EMPLOYEE (SUBSCRIBER) INFORMATION	
1. Patient's Full Name (Please Print)	**6.** Employee's Full Name (Please Print)
2. Patient's Birthdate (Mo/Da/Yr)	**7.** Employee's Birthdate (Mo/Da/Yr)
3. Patient's Sex ❑ Male ❑ Female	**8.** Employee's Social Security or AID Number
4. Patient's Address (Street, City, State, Zip)	**9.** Employee's Address (Street, City, State, Zip)
5. Date(s) of Service: From: _____ To: _____ From: _____ To: _____ From: _____ To: _____	**10.** Employee's Daytime Telephone Number:

COUNTY OF CHATHAM) ***ACKNOWLEDGMENT***
STATE OF GEORGIA)

The undersigned hereby acknowledges that he/she understands that it is a crime to knowingly make false statements and representations of fact, or knowingly conceal, cover-up, or fail to disclose any required fact, in any document required by or is necessary to verify, explain, clarify or check for accuracy and completeness of any report required by the Employee Retirement Income Security Act of 1974 ("ERISA") and that any false statement or representation made in reporting may subject him/her to prosecution under 18 U.S.C. §1027, the penalty for which is a fine of $10,000.00 or imprisonment of five (5) years or both. By signing below, the undersigned further hereby acknowledges and agrees to periodic audits in reference to said claims by GSA-ILA Employers Welfare Fund auditors. I further hereby certify that the procedures or supplies as indicated above have been completed or delivered and that the fees submitted are the actual fees I have charged this patient and intend to accept for those procedures or supplies.

(Name of Attending Dentist) _____ Date: _____ Attending Dentist signs here **X** _____

Please file claim with:

Mailing Address:
ILA EMPLOYERS WELFARE FUND
POST OFFICE BOX 1280
SAVANNAH, GEORGIA 31402-1280

Rev. 05-23-12