MASSACHUSETTS STATE HEALTH CARE PROFESSIONALS' DENTAL FUND

For Internal Use Only:

RECEIVED DATE: ___/___/____

EDUCATION BENEFIT CLAIM FORM

FOR PROPER PROCESSING OF YOUR CLAIM, PLEASE COMPLETE ALL REQUESTED INFORMATION

EMPLOYEE SOCIAL SECURITY NUMBER | SEX (M F) | EMPLOYEE BIRTHDATE (MM DD YYYY) | PROFESSIONAL DISCIPLINE (I.E. LICENSE/JOB TITLE)

EMPLOYEE NAME: LAST (AS SHOWN ON YOUR PAYSTUB) | FIRST | MI

HOME ADDRESS (STREET, APARTMENT NUMBER)

CITY | STATE | ZIP CODE | HOME PHONE NUMBER

CELL PHONE NUMBER | EMAIL ADDRESS

REQUIRED DOCUMENTATION:
The education benefit may be used by members of the Massachusetts Nurses Association, Unit 7 Bargaining Unit ONLY in accordance with the Education Benefit General Information and Reimbursement Guidelines. In addition to the completed claim form, your documentation must include the following:

1.) Name of eligible employee/member;
2.) Name of class or program or related license;
3.) Detailed description of the education course and evidence of course completion or copy of license;
4.) Evidence of incurred cost and final payment

MAXIMUM PAYMENT:
The maximum payment for this benefit is $125 per education benefit year (September 1 through August 31).

Claims will be paid twice per month. Claims received on or before the 15th day of the month will be paid in the month they were submitted. Claims received after the 15th of the month will be paid in the following month.

All claims must be received by Alicare, or if sent by U.S. mail postmarked, within sixty (60) days of the date the continuing education course or program is completed or the date the license is issued.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release to Alicare and its agents of any evidence or information about me that may pertain to this or any related claim. A copy of this authorization shall be valid as the original.

PRINT NAME:	**SIGNATURE:**	**DATE SIGNED:** ____/____/_____

Email, Mail or Fax Completed Claim Form to:
Massachusetts State Health Care Professionals' Dental Fund, Attn: AliCare Department
P.O. Box 5431, White Plains, NY 10602-5431
Phone: (800) 338-4330 **Fax:** (914) 367-5793 **Email:** MassNurseEnrollments@AliCare.com

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT 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.