Revised 02/06/2024

SENECA - CAYUGA NATION

Phone: 918-791-6025
Fax: 918-786-9245

Benefits Department
PO Box 453220
Grove, OK 74354

Email:
benefits@sctribe.com

Benefit Application for DENTAL

Submit to the above Address – "Attention: Benefits"

APPLICATIONS MUST BE COMPLETE OTHERWISE THEY WILL NOT BE PROCESSED

All applications will be processed according to the date the it is received in our office . Your claim must show the amount paid by your insurance company, if applicable

Depending on funding availability the **MAXIMUM** amount paid per Tribal Member for Dental Claims:

***Treatment** - $1500.00 Per Fiscal Year; ***Braces** - $1,500.00 Per Lifetime; ***Dentures** - $1,500.00 Per Fiscal Year

☐ If you have a new address, check this box to update your address with ALL departments of the Nation.

Date _____

Name _____ **Roll #** _____ **Date of Birth** _____

Address _____ **City/State** _____ **Zip Code** _____

Phone Number _____ **Cell Number** _____ **Work Number** _____

Email Address _____

Amount Applying for Dental $ _____

All information provided on this form is true and complete to the best of my knowledge. If asked by an authorized official, I agree to provide proof of the information I have provided on this form. I agree to notify the Seneca-Cayuga Benefits Department of any changes in the above information.

PERMISSION FOR RELEASE OF INFORMATION

I, the undersigned tribal member do hereby give my permission for the release of vendor information to the Seneca Cayuga Nations Benefit Department. This shall include, but not be limited to landlord payments, landlord leases, dental, vision, optical receipts, utility vendors, and any other documents submitted. Any tribal member found to be defrauding the Seneca Cayuga Nation Benefit Program will be suspended indefinitely. Disrespectful behavior to Seneca Cayuga Employees shall also be cause for suspension.

Printed Name of Applicant or Guardian _____ **Date** _____

Signature of Applicant or Guardian _____ **Date** _____

The following documents Must be Submitted with this Application:

- A copy of the tribal card for the member applying for services.
- The invoice or statement from the dentist's office showing the amount **and Tribal Member's name**.
  Note: *If the bill was paid by the Tribal Member or parent, a statement showing the amount must be provided by the dentist to be reimbursed*
- Signed application by the Tribal Member. (parent or guardian if a minor)
- W-9 Tax Form from the dentist's office. Payment will be made directly to the doctor's office.