



Dental Bursary Application

The intention of this fund is to provide short-term relief to SGPS members who find themselves in severely restricted financial circumstances as a direct result of dental costs which are covered at 10% by the SGPS Dental Insurance Program.

Personal Information

Name: _____

Department: _____

Address: _____

Phone: (____) _____ - _____ **E-Mail:** _____

Financial Information

Amount of funding requested: \$ _____

Please include the following with your application:

Predetermination of benefits coverage letter from GreenShield

or

Determination of benefits coverage letter from GreenShield

I certify the above to be true: _____ Date: _____

Applicant's Signature

SGPS Office Use Only (5235)

Approved By: _____ Amount: \$ _____