* An itemized paid receipt must accompany all reimbursement requests. Requests submitted without a paid receipt will not be accepted.
* The first six hundred dollars ($**600.00**) of eligible dental expense incurred for each covered individual during the period of July 1 - June 30 will be reimbursed to the employee within thirty (30) days of submission. The total amount of dental reimbursement is limited to $2500 per year per individual for whom a claim is filed. If there is money left in the fund after all claims have been paid to the maximum, claims in excess of $2500 will be paid on a prorated basis for remainder of the dental fund.
* All other dental expenses in excess of six hundred dollars ($600.00) incurred during the benefit year of July 1-June 30 will be reimbursed on a prorated basis the following August.
* Two (2) cleanings are allowed per year. One complete set of x-rays is allowed per year.
* Dental whitening or bleaching treatments are not eligible expenses
* Dental veneers are not eligible expenses
* The maximum reimbursement amount for orthodontic treatment is one thousand dollars ($1000.00) per year. Requests for reimbursement must be submitted within 12 months of date of payment and be accompanied by a paid receipt.
* The maximum reimbursement amount for dental implants will be one thousand five hundred dollars ($1,500) per year.

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| **PATIENT NAME:** | **EMPLOYEE NAME & ID #:** |
| **PATIENT BIRTHDATE:** | **RELATIONSHIP TO EMPLOYEE:** |
|  |
| **Date of Service** | **Description of Service** | **Fee Charged** | **Discount extended by Dentist** | **Amount Paid by Insurance** | **AMOUNT PAID BY EMPLOYEE** (receipt must be attached) |
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| **Total Amount Charged:** |  |  |
| **Total Paid by Insurance:** |  |  |
| **Total Paid by Employee:** **(this amount should be reflected on the attached paid receipt)** |  |  |

EMPLOYEE SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HR APPROVAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_