* An itemized paid receipt must accompany all reimbursement requests. Requests submitted without a paid receipt will not be accepted.
* The District shall establish a Dental/Optical Fund in the amount of 20,000. Any money not expended during a given year will be added to the funds available for the following year.
* All Requests for reimbursement from July 1 through June 30th of the year must be received no later than July 10. The First two Hundred dollars ($200.00) of eligible dental/optical expense per each covered individual (Coverage under this section is Limited to Husband, wife, and dependent children.) for covered expenses during the period of July 1st through June 30th will be reimbursed to the employee within thirty (30) days of submission.
* All other dental/optical expenses in excess of two hundred dollars ($200.00) incurred during the fiscal period will be reimbursed on a prorated basis if necessary and paid on an august payroll.
* Two (2) cleanings are allowed per year. One complete set of x-rays is allowed per year.
* Limit of one hundred dollars ($100.00) toward orthodontics,
* Bleaching, implants and veneers are not covered expenses
* One optical exam is permitted
* One complete set of glasses with lenses (limit of $100 toward the frame) OR Two hundred dollars ($200.00) towards contacts.
* The amount of reimbursement under this section is limited to fifteen hundred dollars ($1500.00) per employee family

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| **PATIENT NAME:** | **EMPLOYEE NAME:** |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_