* An itemized paid receipt must accompany all reimbursement requests. Requests submitted without a paid receipt will not be accepted.
* Actual dental service must be rendered during the period which runs July 1 to June 30 for reimbursement. Forms must be turned in prior to July 10 of the following fiscal year. Dental claims turned in after July 10 will be paid on the next yearly pay period. Forms must be submitted within twelve (12) months of service.
* Any employee who is entitled to dental coverage under this article and who has similar coverage under other dental plans, will be reimbursed (on a prorated basis if necessary) up to the amount not covered under the other dental plan.
* Coverage under this article is limited to husband, wife and dependent children living at home and/or claimed on federal tax return.
* Two (2) cleanings are allowed per year. One complete set of x-rays is allowed per year.
* Bleaching, implants and veneers will not be covered.
* The maximum for orthodontics is one thousand dollars ($1000.00) per year for each individual.
* 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. All other dental expenses in excess of six hundred dollars ($600.00) incurred during the period will be reimbursed on a prorated basis if necessary during the following august. Any money not expended during a given year will be added to the funds available for the following year.
* The amount of reimbursement under this Section is limited to twenty-five hundred dollars ($2500.00) per year per individual for whom a claim is filed. If there is money left in the fund after claims have been paid, claims over twenty-five hundred ($2500.00) will be paid on a prorated basis to the maximum available funds in the account.

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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_