* An itemized paid receipt must accompany all reimbursement requests. Requests submitted without a paid receipt will not be accepted.
* The dental/optical forms submitted during the course of the school year, will be reimbursed by July 31 of each year. Should the total approved bills submitted during the course of the school year exceed the amount in the fund, then reimbursement will be prorated – so many center per dollar. The amount in the fund for each year of the contract shall be $15,000 per year.
* The following rules will govern the fund:
1. The employee must have completed the ninety (90) day probationary period before being eligible to receive payment from the Dental/ Optical Fund.
2. An employee may submit no more than one (1) claim per year for an eye exam.
3. An employee may submit no more than one (1) claim per year for a set of glasses or for a set of contacts.
4. Any employee being paid less than four (4) regularly assigned hours per day shall receive reimbursement at one-half (1/2) the prorated amount paid to full time employees (those working four (4) hours per day or more)
5. Cosmetic procedures are not covered
* An employee must be regularly assigned to ten (10) hours of work per week or more in order to benefit from this dental/optical coverage
* Any employee who is entitled to dental/optical coverage under this article, and who has similar coverage under other dental/optical plans, shall be reimbursed (on a prorated basis if necessary) up to that amount not covered under the other dental/ optical plan. Abuse of this provision, namely seeking double payments, will result in non-participation in this plan for a minimum of two (2) fiscal years as well as possible other disciplinary action.
* Coverage under this article is limited to husband, wife, and dependent children.
* Should any of the amounts budgeted not be utilized during their scheduled year, then the amount not paid out will be carried over to the succeeding fiscal year.

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