

DENTAL REIMBURSEMENT CLAIM FORM

Employee Name _____

<u>Date of Service</u>	<u>Patient</u>	<u>Relationship to Employee</u>	<u>Amount</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Total amount to be reimbursed....._____

I certify that the statements and information included in this claim are true and accurate to the best of my knowledge. I also certify that I am claiming reimbursement for eligible expenses incurred during the Plan Year and only for eligible plan participants. I also certify that these expenses have not previously been reimbursed under this or any other benefit plan. I further certify that I will not claim these or any other expenses reimbursed through this plan, as an income tax deduction.

Employee Signature _____ Date _____

Attach to this claim the bill (s) or receipt (s) from your dentist.