SOLANCO SCHOOL DISTRICT

DENTAL/VISION REIMBURSEMENT FORM

EMPLOYEE NAME:_______________________________________ **ADDRESS:**___________________________________

To make application for benefits email this completed form to **DentalandVision@solancosd.org** along with **paid** receipt. You may also send the form and receipts via PONY or USPS to the Business Office c/o D/V Reimbursement. Cancelled checks and statements are not acceptable.

1. During each contract year, each employee shall be granted reimbursement, as listed below, for expenses incurred during the contract year for dental and vision care by properly licensed professionals for the employee, employee's spouse, and employee's children*. (*Dependent – someone still carried on your tax return.)

   2019-2020 - $2,250.00 **2020-2021** - $2,250.00 **2021-2022** - $2,250.00 **2022-2023** - $2,300.00 **2023-2024 -** $2,300.00

2. Non-prescription glasses/sunglasses are not covered unless prescribed for medical reasons.
3. Orthodontic payment plans/financing arrangements shall be subject to a one-time $100.00 deductible for the life of each orthodontic plan.
4. To be eligible for reimbursement, all expenses must be submitted within the same contract year in which they are incurred. Expenses incurred in June may be submitted not later than **August 15** of the following contract year unless an extension is granted in writing by the Superintendent or his/her designee.
5. Dental expenses must be noted as a dental code; i.e. not a medical code.

Dental/Vison reimbursement benefit is non-cumulative and is conditional upon presentation to the Business office of dental or vision bills for appropriate services (i.e. supplies are generally not covered). Reimbursement shall be paid promptly following the board meeting after submission of bills, providing such submission occurs not later than the first business day of the month of the board meeting.

DATE EXPENSE WAS INCURRED	NAME OF DOCTOR	NAME OF FAMILY MEMBER AND RELATIONSHIP	*DENTAL EXPENSE AMOUNT	*VISION EXPENSE AMOUNT
************	******************	***************** **TOTALS**	$	$

***If expense is for an orthodontia payment plan**:
Plan Term Beginning Date______________________
Plan Term Ending Date ______________________

EMPLOYEE CERTIFICATION

I hereby certify that all expenditures itemized above were made by myself or my eligible dependents, and are not the subject of any compensation or reimbursement from any other source.

_______________________________________ ________
Signature Required **Date**

BUSINESS OFFICE USE ONLY:

VENDOR #________________

ACCOUNT #____AMOUNT PAID____________

ACCOUNT #____AMOUNT PAID____________

TOTAL PAID ____________