**SOLANCO SCHOOL DISTRICT**

**DENTAL/VISION REIMBURSEMENT FORM**

**EMPLOYEE NAME:**_____ **ADDRESS:**_____

To submit a request 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 the fiscal years 2024-25 through 2027-28, full-time employees shall be granted a maximum reimbursement of **$2,300.00** for eligible expenses incurred during the fiscal year for dental and vision performed by properly licensed professionals for the employee, employee's spouse, and employee's children*. (*Dependent – individual carried on your tax return.)
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 fiscal year in which they are incurred. Expenses incurred in June may be submitted not later than **August 15** of the following fiscal 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, not a medical code.
6. Protection plans and other payment plans that do not represent actual dental or vision services are NOT eligible for reimbursement.

**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 |
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***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 _____