REIMBURSEMENT CLAIM FOR P/T FACULTY DENTAL

4.2 (e) **Dental Coverage**. Unit members who qualify for health care coverage in 4.2 above shall qualify for a reimbursement of up to $400 per fiscal year for a single subscriber, or $800 per fiscal year for a subscriber plus one, based on submission to the District of an itemized invoice from a dentist outlining the services provided, submitted within 30 calendar days of the end of the fiscal year. The District shall reimburse the unit member within 30 days of receipt of a verified itemized invoice. The maximum total dental reimbursement shall not exceed the prior year expenditures by more than $15,000 per fiscal year ($5,000 funded from District General Fund and $10,000 funded from category V, IR&D Grant). Should actual claims be less than $15,000, the unexpended amount shall, in the subsequent contract year, be added to the funds allocated to Category V Grants provided in Article 8 of the CBA.

DATE: _____

NAME: _____ M00_____
(printed)

PHONE NUMBER: _____

_____

UNITS TAUGHT: FALL SEMESTER_____SPRING SEMESTER_____
(minimum of 6 units)

DATE OF DENTAL VISIT: _____ _____ _____ _____

PATIENT: _____ _____ _____ _____

CLAIM AMOUNT: $_____ $_____ $_____ $_____

TOTAL THIS REIMBURSEMENT: $ _____

_____
(employee signature)

FISCAL SERVICE USE ONLY
CHARGE ACCOUNT NUMBER: 61100-37201-54500-000000

APPROVAL: _____