

DENTAL / OPTICAL REIMBURSEMENT
(Deadline June 10th of School Year**)**

****Please submit a statement of services rendered including dates, services or items purchased along with the cost****

~THE AMOUNT PAID OUT OF POCKET MUST BE LISTED IN ORDER TO RECEIVE REIMBURSEMENT~

(Claims must have appropriate paperwork in order to be processed)

PLEASE PRINT:

EMPLOYEE'S

Name: _____

Address: _____

Phone Number: _____

Position: _____

Please check the family member for whom you are submitting a claim.

SELF _____ SPOUSE _____ CHILD _____

CENTRAL OFFICE WILL COMPLETE BELOW THIS LINE

Dates of Service: _____

Pay from Budget Code: _____

Amount: _____

Date of Payment: _____

Signed: _____

**Send form to:
Myra Darnell
Payroll/Benefits
Greene County Schools**