One-Time Dental Care Reimbursement Authorization

Use This Form For Dental Care Expenses Incurring
September 1, 2005 through August 31, 2006

FILING INFORMATION

- **This claim form is *ONLY* used for participants whose dental claims are processed through the JFT Health and Welfare Fund dental claims system.**
- **This form serves as authorization to the JFT Health and Welfare Fund to reimburse you from your Health Care Flexible Spending Account for out-of-pocket dental expenses incurred during the Plan Year.**
- **Your out-of-pocket dental expenses will be automatically reimbursed to you as long as you have not exhausted the funds in your Health Care FSA.**
- **Revocation, or amendment, of this form must be in writing, and sent by certified mail, or hand-delivered with receipt of delivery.**
- **Sign this claim form and mail it, or send it through the Pony, to the address listed at the bottom of the claim form.**
- **You may want to keep a copy of your form for your personal record.**

CLAIM INFORMATION

(PLEASE PRINT OR TYPE)

Name of Employee: ____
(Last) (First) (MI)

Social Security Number: ______________________ Home Phone: ______________________

Does anyone, including yourself, currently covered under your JFT Health and Welfare Fund Fee-For-Service Dental Plan have dental coverage elsewhere: ○ Yes ○ No

If Yes, please list all persons including yourself who have other dental coverage (use back for additional persons):

______________________ ______________________
(First) (Last) (First) (Last)

______________________ ______________________
(First) (Last) (First) (Last)

______________________ ______________________
(First) (Last) (First) (Last)

To the best of my knowledge, my statements on this Reimbursement Request are complete and true. I understand that should any statement on this form change during the Plan Year, I will contact the Fund. I am solely responsible for the validity of claims submitted to my Flexible Spending Account. I authorize reimbursement only for eligible dental expenses incurred during the Plan Year shown above. I certify that the dental expenses of myself and my dependents are not reimbursable by any other source, nor will I claim these expenses for reimbursement by any other source.

____
Employee Signature *Date*

Jefferson Federation of Teachers
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