Dental Claim Form

This claim form is to be used to request reimbursement from your Dental Plan. You will need to include invoices/statements that include dental codes when submitting a claim for reimbursement.

This form is not to be used for Health Care FSA dental reimbursements.

IN ALL CASES, YOU MUST SIGN THE BOTTOM OF THIS FORM

Date Expense Incurred	Name of Service Provider	Expense Description	Relation to Person for Whom Expense Incurred (i.e. self, son, daughter, spouse)	Amount
			Total	

NOTE: You will need to include an invoice/statement that includes dental codes when submitting a claim for reimbursement. Credit card receipts and canceled checks by themselves are not acceptable forms of claim substantiation.

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Dental Plan. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned and that unless an expense for which payment or reimbursement is claimed as a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned fully understands that no medical expense tax deduction or credit is permitted for which reimbursement is made.

_____
Employee Name (Please Print)

_____ _____
Employee Signature Date

When done, attach all necessary receipts and **scan & email, fax or mail** to:

Northeast Benefits Management, LLC
P.O. Box 2363, South Burlington, VT 05407-2363
Scan and email: info@nbmus.com
Fax: (802) 419-3094

NBM
Employee Benefits Simplified