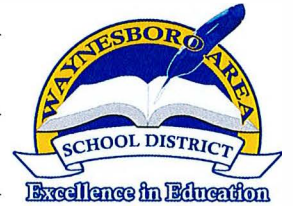


Dental-Vision Reimbursement Form

NAME	_____
BUILDING	_____



Type of Request: Dental Vision

- APPOINTMENT FOR: _____
- APPOINTMENT FOR: _____
- APPOINTMENT FOR: _____
- APPOINTMENT FOR: _____

AMOUNT:	_____
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<i>Employee Signature</i>	_____
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ONLY ANSWER THE BOTTOM PORTION OF THIS FORM IF YOU HAVE A SPOUSE & YOUR SPOUSE IS EMPLOYED.

Name of Employer: _____

- Does employer provide dental and or vision coverage?
 No Coverage Dental Vision
- IF employer provides coverage, what age are children covered to?
 I don't Know Age 23 Age _____

Each submission must have a paid invoice, detailed receipt, and an EOB (if necessary).

Email submission to Dental_Vision@wasdpa.org

If you have questions, please contact Chelsea Sanders at Chelsea_Sanders@wasdpa.org or (717)-762-1191 x1144