

Briarcliff Manor SRP Request for Dental Reimbursement Expenses

Return completed form to:
 J.J. Stanis & Company, Inc.
 377 Oak Street Suite 406
 Garden City, NY 11530
 Fax Number 1-516-465-3920

Email claims to: claims1@jjstanisco.com

Employer _____

Employee Name _____ SS No. _____
Last First Middle

Home Address: _____
Number/Street City State Zip

Please check only if this is a new address. Daytime Telephone Number _____

DENTAL EXPENSES REIMBURSEMENT PLAN

- ◇ \$500 reimbursement PER SRP Member per fiscal year
- ◇ Fiscal year is July 1 through June 30
- ◇ Claim filing is 180 days from the end of the fiscal year (i.e.: Filing limit for expenses incurred 7/1/2024 through 6/30/2025 is 12/31/2025)
- ◇ Attach a copy of the bill listing services rendered by the Dentist/Orthodontist (credit card receipts are NOT acceptable)
- ◇ Cosmetic services are not covered

Date of Service	For the Benefit of (Employee Name)	Description of Service	Provider of Service	Requested Amount

Employee Signature: _____ Date: _____

If you have questions about a claim, please call (516) 465-3900 between 8:30 a.m. and 5:00 p.m. ET, Monday through Friday.