ROCHESTER AREA SCHOOL DISTRICT
DENTAL REIMBURSEMENT FORM

Dental Reimbursement Request Form

Based on your collective bargaining agreement with the Rochester Area School District, you are eligible for annual dental reimbursement as outlined below.

Annual Dental Reimbursement Benefit

The District will reimburse each eligible employee and their eligible dependents for qualified dental expenses (including orthodontic services) up to the following annual maximum per person:

School Year	Annual Maximum
2024–2025	$1,200
2025–2026	$1,400
2026–2027	$1,600
2027–2028	$1,800
2028–2029	$2,000

To receive reimbursement, submit this completed form along with a **paid dental invoice or receipt** to the Business Office. Reimbursement will be processed within **ten (10) business days** after proof of payment and service is received.

Employee Name: _____

Employee Signature:_____

Patient Name:_____

Invoice Amount (attach invoice):_____

TO BE COMPLETED BY BUSINESS OFFICE

Date received:_____

Total Amount Reimbursed for Patient for current fiscal year can not exceed $1600