Waynesboro Area School District
Request for Reimbursement Dental/Vision

Name: _____Last 4 SS#:_____Building_____
(OPTIONAL)

Full Time _____ Part Time _____

Type of Request
Dental: _____ Self _____ Spouse _____ Dependent _____
Vision: _____ Self _____ Spouse _____ Dependent _____

Is your spouse employed? _____ Yes _____ No If yes, employer: _____Phone# _____

Does your spouse's employer provide coverage for: **Dental?** ___ Yes ___ No **Vision?** ___ Yes ___ No

Are dependents covered? ___ Yes ___ No If yes, to what age? _____

Amount Requested	

_____ _____

Employee's Signature **Date**

A copy of the paid invoice(s) with breakdown of charges and/or a copy of coordination of benefits must be attached.

Please forward request to the Waynesboro Area School District Business Office Attn. Susan Patterson.