July 1, 2024

AVONDALE SCHOOL DISTRICT 2024-2025 DENTAL REIMBURSEMENT SCHEDULE

To: Non Rep Members

For your dental claim to be processed, the reimbursement form must be completely filled out with a paid receipt for services attached to the back (one form for each family member). If you are submitting claims for more than one family member, but all payments are on the same receipt, please make a copy of the receipt and attach to each claim form.

Covered expenses included two cleanings and one set of x-rays per year. Bleaching and veneers will not be covered. The maximum for orthodontics is $1,000 per year. The maximum for implants will be $1,500.

The first $600 in claims for each family member will be reimbursed as the claims are received following the schedule below. For all balances over the $600, the prorated payout will take place in late August of 2025. You may submit up to $2,500 per family member for services from July 1, 2024 through June 30, 2025. Of the $2,500 submitted, up to $1,000 of it may be for orthodontics for each individual.

All reimbursements will be paid through payroll.

Forms due to HR by:	Check Issued:
Friday, September 6, 2024	Friday, September 27, 2024
Friday, October 4, 2024	Friday, October 25, 2024
Friday, November 1, 2024	Friday, November 22, 2024
Friday, December 6, 2024	Friday, December 20, 2024
Friday, January 3, 2025	Friday, January 17, 2025
Monday, February 3, 2025	Friday, February 28, 2025
Friday, March 7, 2025	Friday, March 28, 2025
Friday, April 4, 2025	Friday, April 25, 2025
Friday, May 2, 2025	Friday, May 23, 2025
Friday, June 6, 2025	Friday, June 20, 2025
FINAL PAYOUT FOR 2024-2025 SCHOOL YEAR FOR SERVICES AND PAYMENT BEFORE July 1, 2025	
Monday, July 10, 2025	August 15, 2025

Please submit all claims to Annamaria Wyman in the Human Resources office

Mail to: 2940 Waukegan Street, Auburn Hills, MI 48326

Scan and Email to: dentalclaims@avondaleschools.org

Please do not fax

Dental Reimbursement Request

- An itemized paid receipt must accompany all reimbursement requests. Requests submitted without a paid receipt will not be accepted.
- Actual dental service must be rendered during the period which runs July 1 to June 30 for reimbursement. Forms must be turned in prior to July 10 of the following fiscal year. Dental claims turned in after July 10 will be paid on the next yearly pay period. Forms must be submitted within twelve (12) months of service.
- Any employee who is entitled to dental coverage under this article and who has similar coverage under other dental plans, will be reimbursed (on a prorated basis if necessary) up to the amount not covered under the other dental plan.
- Coverage under this article is limited to husband, wife and dependent children living at home and/or claimed on federal tax return.
- Two (2) cleanings are allowed per year. One complete set of x-rays is allowed per year.
- Bleaching and veneers will not be covered.
- The maximum for orthodontics is one thousand dollars ($1000.00) per year for each individual.
- The first six hundred dollars ($600.00) of eligible dental expense incurred for each covered individual during the period of July 1 – June 30 will be reimbursed to the employee within thirty (30) days of submission. All other dental expenses in excess of six hundred dollars ($600.00) incurred during the period will be reimbursed on a prorated basis if necessary during the following august. Any money not expended during a given year will be added to the funds available for the following year.
- The amount of reimbursement under this Section is limited to twenty-five hundred dollars ($2500.00) per year per individual for whom a claim is filed. If there is money left in the fund after claims have been paid, claims over twenty-five hundred ($2500.00) will be paid on a prorated basis to the maximum available funds in the account.

PATIENT NAME:	**EMPLOYEE NAME:**
PATIENT BIRTHDATE:	**EMPLOYEE ID #:**
RELATIONSHIP TO EMPLOYEE:	

Date of Service	**Description of Service**	**Fee Charged**	**Discount extended by Dentist**	**Amount Paid by Insurance**	**AMOUNT PAID BY EMPLOYEE** (receipt must be attached)
Total Amount Charged:					
Total Paid by Insurance:					
Total Paid by Employee: **(this amount should be reflected on the attached paid receipt)**					

EMPLOYEE SIGNATURE: _____ DATE: _____

HR APPROVAL: _____ DATE: _____