DENTAL/VISION EXPENSE REIMBURSEMENT FORM

To ensure timeliness in processing, please fill out claim form completely and accurately, sign, date, and Attach an itemized statement or receipt that includes Description of Service, Date of Service, and Amount of Charge.

Please put your AGA ID Number on your itemized statement or receipt.

Employee Information

Name		
Phone Number	Group Name	Group Number

Claim Information

Date of Service	Person Incurring Expense	Relationship	Provider	Description of Service	Amount Charged

Total Claim Amount $ 0.00

I request the attached expenses be paid under my employer's benefits plan. I certify that:

- I, or my eligible dependents, have incurred these expenses during this plan year
- I understand that I am responsible to provide necessary documentation to substantiate the expense is eligible.
- I understand that I may not be reimbursed for the total claim amount and may be responsible for deductibles, copays, coinsurance, amounts above maximum benefit, and or excluded items.
- These expenses have not been reimbursed from any other source, nor do I expect them to be.

Employee Signature _____ Date _____