EAST ISLIP PUBLIC LIBRARY
381 East Main Street
East Islip, NY 11730-2896

Dental Reimbursement Form

Employee Name:

Date of Service:	Provider's Name:	Amount Claimed:

Please Attach Supporting Documentation

I hereby certify that I am not covered by any other plan for reimbursement for the amount of money claimed on this form.

Signed: _____ Date:_____