MSP (Pvt.) Ltd.

EMPLOYEE DENTAL REIMBURSEMENT FORM

Instructions:

Please ensure the following when completing this form:

Complete the required expense details ensuring no section is left blank.
Ensure all receipts attached are original and no photocopies/scanned copies are submitted.
Receipts are not older than 3 months from submission time-line.
Claim does not exceed the available medical limit, please refer to your salary slip on **MSP Portal** for confirmation.

Notes:

The company reserves the right to refuse reimbursement of any medical cost not covered in the medical policy or whereby the requirements are not complete.
The company reserves the right to acquire any additional documentation/information to satisfy the requirements for expense reimbursement.
If you have any queries or require further information kindly Contact MSP HR representative.

EMPLOYEE DETAILS	**Employee Name:**	**Employee Number:**
	Department:	**Division:**
CONTACT DETAILS	**Email ID:**	**Official Cell #:**

Expense Details:

Tick all those that apply and provide expense details:

	Treatment Type	Please enter amount
☐	Consultation Charges	
☐	Treatment Charges	
☐	Medicines Cost	
☐	Others	

Treatment Details:

Treatment Details:	
Total: Rs.	0

Claimant's Declaration:

I hereby declare that I have read and understand the above instructions and declarations and take the full responsibility/ownership of the claim being submitted.

Claimant's Signature & Date

FOR OFFICIAL USE ONLY

Deduction Details:

MSP Representative Signature & Date

HR Representative Signature & Date