The College of New Jersey

REQUEST FOR VISION CARE REIMBURSEMENT

INSTRUCTIONS

Complete sections I though IV below and attach the original receipt(s) corresponding to the vision care expenses for which you are requesting reimbursement. A separate reimbursement request form must be submitted for each employee, spouse, or eligible dependent.

PLEASE TYPE OR PRINT

I. EMPLOYEE INFORMATION Employee ID_____

Employee Name_____ Department_____

Name of Health Carrier_____ Campus Phone_____

Dependent's Name (if applicable)_____ Dependent's Date of Birth_____

Are you or your dependent(s) eligible for vision care benefits under any other health insurance carrier? Yes ☐ No ☐

If yes: Name of Insurance Company_____

Policy or Identification Number_____

II. ELIGIBLE EXPENSES (This section MUST be completed in its entirety.)

EYE EXAMINATION

1. AMOUNT PAID FOR EYE EXAMINATION _____
2. LESS AMOUNT TO BE REIMBURSED BY HEALTH CARRIER(S) _____
3. LESS AMOUNT TO BE REIMBURSED BY COUPON OR PAID BY ANY OTHER SOURCE _____

TOTAL OUT-OF-POCKET EXPENSE FOR EYE EXMINATION _____

CORRECTIVE LENSES

TYPE OF CORRECTIVE LENSES PURCHASED

SINGLE VISION GLASSES ☐ BIFOCALS OR TRIFOCALS ☐ CONTACTS ☐

1. AMOUNT PAID FOR CORRECTIVE LENSES _____
2. LESS AMOUNT TO BE REIMBURSED BY HEALTH CARE CARRIER(S) _____
3. LESS AMOUNT TO BE REIMBURSED BY COUPON OR PAID BY *ANY* OTHER SOURCE _____

TOTAL OUT-OF-POCKET EXPENSES FOR CORRECTIVE LENSES _____

III. EMPLOYEE'S REQUEST FOR REIMBURSEMENT*

I am requesting reimbursement for an eye examination in the amount of _____(a maximum of $35.00 or the final cost to employee, whichever is less).

I am requesting reimbursement for corrective lenses in the amount of_____(up to $40.00 for single vision lenses, or up to $45.00 for bifocals, trifocals or contact lenses, for the final cost to employee, which ever is less).

*Reimbursement may not exceed out-of-pocket expense

IV. EMPLOYEE'S STATEMENT

I certify that the information contained in this application is accurate and that the attached receipt represents a valid claim for reimbursement for Vision Care expenses incurred by my eligible dependent or me named herein. I fully understand that my total reimbursements (reimbursements through my health care carrier plus the amount reimbursed though the College, or any other source) *by law, may not exceed my out-of-pocket* expense.

Employee's Signature_____Date Signed_____

V. THIS SECTION TO BE COMPLETED BY THE OFFICE OF HUMAN RESOURCE

VERIFICATION

EYE EXAMINATION

Vendor_____Phone Number_____

Person spoken to_____Date_____

Comments _____

APPROVED ☐ AMOUNT REIMBURSED_____ PAY PERIOD_____

DISAPPROVED ☐ REASON: _____

CORRECTIVE LENSES

Vendor_____Phone Number_____

Person spoken to_____Date_____

Comments_____

APPROVED ☐ AMOUNT REIMBURSED_____ PAY PERIOD_____

DISAPPROVED ☐ REASON: _____

Authorized Signature_____Date_____