Vision Care Program Reimbursement Request

Employee's Name: _____ Union Type: _____

An itemized receipt from the vision care provider with the patient's name, the date of service, the service rendered, and the amount paid for each service must accompany this form. Reimbursement cannot be processed without a valid itemized receipt. A credit card receipt without names or itemized purchases will not be accepted.

- For eyeglass or contact lenses reimbursement, the employee shall obtain a receipt from the optician indicating the date, type of lens and the full name of the person receiving the glasses or contact lenses.
- For eye examination reimbursement, the employee shall obtain a receipt from an optometrist or ophthalmologist indicating the date of the eye examination and the full name of the person examined.

Reimbursement of Vision Care Program service(s) is requested for:

☐ Self ☐ Spouse ☐ Civil Union/Domestic Partner ☐ Dependents (under 26 years of age)

Name of Spouse/ Civil Union/Domestic Partner: _____

Name of Dependent Child: _____ **Date of Birth**: _____

Service Type (Please Select**):**

☐ Eye Exam **Date: _____**

☐ Eye Exam Co-Payment **Exam Copay: $_____**

Type of Lenses (Please Select): **Purchase Date**: _____

☐ Single-Vision Eyeglasses/ Contact Lenses ☐ Progressive Eyeglasses/ Contact Lenses

☐ Bifocal Eyeglasses/ Contact Lenses ☐ Trifocal Eyeglasses/ Contact Lenses

By completion of this form, I certify that this represents a valid claim for reimbursement of Vision Care received by me or my eligible dependent(s), named herein, and is the only claim requested during the current contract period for me and/or the eligible dependent so named.