Vision Care
Reimbursement Request Form

GENERAL ACCOUNTING USE ONLY

Kean University
Office of Human Resources
1000 Morris Avenue
Union, NJ 07083

Voucher No. ______________________
Voucher Date ______________________
AP Type ______________________

INSTRUCTIONS FOR COMPLETION:

1. Complete all information requested below in EMPLOYEE SECTION. PLEASE PRINT.
2. Attach all receipts pertaining to this request for reimbursement. The reimbursement request for the current benefit period MUST be submitted to Human Resources by July 12, 2019.
3. The receipt must be the original and itemized. It must include the patient name (yours or your dependents'), the date of service, the exam type, the lens/contact type purchased. It must also include the provider's name, address, and telephone. (A credit card receipt without names or itemized purchases will not be accepted for reimbursement.)

Due to the expiration of collective bargaining agreements, this reimbursement program is currently only available to members of AFT, CWA and IFPTE as well as Managerial employees. The Vision Care Reimbursement Program is subject to change upon the ratification of new collective bargaining agreements.

EMPLOYEE SECTION - TO BE COMPLETED BY THE EMPLOYEE

____
EMPLOYEE'S NAME

____
Employee's Kean ID #

____
EMPLOYEE'S HOME ADDRESS

____

(__________) ____________ - ______________
EMPLOYEE'S DAY TIME TELEPHONE NUMBER

This claim is for:

______ SELF _____DEPENDENT _____SPOUSE

____
NAME OF DEPENDENT/SPOUSE

Exam	$35.00______	Single Lenses	$40.00 ______
		Bifocals	$45.00 ______
		Trifocals	$45.00 ______
		Contacts	$45.00 ______

I certify that this bill represents a valid claim for reimbursement for Vision Care received by me or my eligible dependent named herein and it is the only claim requested during the current contract period for me and/or the eligible dependent so named.

__________________________ ______________
EMPLOYEE'S SIGNATURE DATE

FOR OFFICE USE ONLY BELOW THIS LINE
Benefit Period is from **JULY 1, 2017 to JUNE 30, 2019**

______ EYE EXAMINATION:

Amount of Claim ____________________

Sub-Total ____________________

LENSES: Single / Bifocals / Trifocals / Contacts:

Amount of Claim ____________________

Sub-Total ____________________

Prepared by: ______________________ ____________ Date

Manager's Authorization: ______________________ ____________ Date

Director's Authorization: ______________________ ____________ Date

Total for this claim reimbursed to the employee:

$

11-73510-5231

General Accounting Office Use Only
Approved by: ____________________________ Date: ____________________________