# 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 14, 2023.
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 not available to members of PBA. The Vision Care Reimbursement Program is subject to change upon the ratification of new collective bargaining agreements.*

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**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

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.

_____
NAME OF DEPENDENT/SPOUSE

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

_____ _____
EMPLOYEE'S SIGNATURE DATE

**FOR OFFICE USE ONLY BELOW THIS LINE**
Benefit Period is from **JULY 1, 2021 to JUNE 30, 2023**

_____ 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: _____