RAMAPO COLLEGE OF NEW JERSEY

DEPARTMENT OF HUMAN RESOURCES
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VISION CARE REQUEST FOR REIMBURSEMENT

INSTRUCTIONS FOR COMPLETING THE VISION CARE REIMBURSEMENT FORM

PLEASE PROVIDE ALL OF THE REQUESTED INFORMATION

1. Please complete **Section one (1) and Section two (2) and Section 3.**
2. This request for reimbursement must be submitted with an original receipt for the eye examination and/or the purchase of lenses.
3. The receipt (s) must be itemized and include the following information:

- ✓ **Amount paid for the services and/or lenses**
- ✓ **The name of the service provider**
- ✓ **The address of the service provider**
- ✓ **Last rates change effective date was July 1, 2005**
- ✓ **Regular Lenses $40, Bifocal/Trifocal Lenses $45, Examination $35**

The frequency of reimbursement is one payment for lenses and one payment for an examination in a two year coverage period.

Section 1: EMPLOYEE INFORMATION	
Name:	Employee ID :
Home Street Address:	City, State, Zip Code:
The Claim is for: ☐ Employee (self) ☐ Spouse ☐ Dependent	
Section 2: DEPENDENT INFORMATION **Must be completed if submitting claim for spouse or dependent**	
Dependent's Name:	Date of Birth:
Section 3: Employee Certification	
I certify that this bill represents a valid claim for vision care reimbursement received by me or my eligible dependent named herein and is the only claim requested during the **current contract period of July 1,** 2021 – June 30, 2023 for myself or my eligible dependent so named.	
Employee Signature:	Date:

EMPLOYER SECTION **Account Number: 10001-72101-6102-60**	**AMOUNT**
Eye Examination	$
Lenses Single Bi/Tri-Focal Contacts	$
Total Reimbursement	$
HR APPROVAL SIGNATURE	**DATE**