RAMAPO COLLEGE OF NEW JERSEY

DEPARTMENT OF PEOPLE OPERATIONS AND EMPLOYEE RESOURCES

o. (201) 684-7506 | f. (201) 684-7508

e. poer@ramapo.edu | ramapo.edu/poer

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 October 16, 2023**
- ✓ **Regular Lenses $80, Bifocal/Trifocal Lenses $90, Examination $45**

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, 2023 - June 30, 2025** 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**