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 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**