Vision Care Program Reimbursement Request

Employee's Name: _____ Date of Service: _____

Reimbursement of Vision Care Program services is requested for:

☐ Self: ☐ Eye Examination ☐ Regular Glasses ☐ Bifocal Glasses

☐ Spouse: Name: _____

☐ Eye Examination ☐ Regular Glasses ☐ Bifocal Glasses

☐ Dependent Child (ren):

Name: _____ Date of Birth: _____

☐ Eye Examination ☐ Glasses

Name: _____ Date of Birth: _____

☐ Eye Examination ☐ Glasses

Name: _____ Date of Birth: _____

☐ Eye Examination ☐ Glasses

By completion of this form, I certify that this represents a valid claim for reimbursement for an eligible vision care service received by myself or my eligible dependent(s).

An itemized receipt must accompany this form. **Reimbursement cannot be made without a valid itemized receipt.**