

**New Jersey Institute of Technology  
Vision Care Reimbursement Form**



*The Vision Care Plan provides a benefit up to \$35.00 for an eye examination, and a reimbursement up to \$35.00 for single vision lenses or contacts or \$40.00 for bifocal and progressive lenses. Frames are not covered. Faculty and staff and their eligible dependents are entitled to receive one reimbursement in a designated two-year period (Example: July 1, 2012 – June 30, 2014).*

**Employee's Name:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Daytime Phone Number:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Eye examination reimbursement for** \_\_\_\_\_  
*(name of person who received the eye exam)*

Self     Spouse     Child     Domestic Partner

**Eyeglasses or Contact Lenses reimbursement for** \_\_\_\_\_  
*(name of person who received lenses)*

Self     Spouse     Child     Domestic Partner

**Type of lenses (please check one):**

Single-vision     Bifocals     Progressive     Contacts

**Date Purchased:** \_\_\_\_\_ **Cost of Lenses:** \_\_\_\_\_

**Employee's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

***Please attach the original receipt to the Vision Care Reimbursement form. Claims will not be processed without the original itemized receipt.***

## **The Vision Care Reimbursement Program**

**Members may use their medical coverage for the eye examination; if so, please attach a receipt showing the co-payment to receive a reimbursement.**

**A reimbursement will be paid to eligible faculty and staff, a spouse or registered same-sex domestic partner, and unmarried dependent children under age 23.**

**Vision Care reimbursement checks are mailed to the employee's home address 3-4 weeks after the Vision Care form has been processed.**

**The original receipt should include the name of the person who received an eye examination, contacts or lenses; the date of purchase, and the type of lenses (e.g. single, vision, bifocals, progressive, contacts).**