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).

2/2007