

Vision Care Reimbursement Request Form

GENERAL ACCOUNTING USE ONLY

Kean University
Office of Human Resources
1000 Morris Avenue
Union, NJ 07083

Voucher No. _____
Voucher Date _____
AP Type _____

INSTRUCTIONS FOR COMPLETION:

1. Complete all the information requested below in EMPLOYEE SECTION. PLEASE PRINT.
2. Attach all receipts pertaining to this request for reimbursement. The reimbursement request for the current benefit period **MUST** be submitted to Human Resources by **July 14, 2025**.
3. The receipt must be itemized. It must include the patient's name (yours or your dependents'), the date of service, the exam type, and the lens/contact type purchased. It must also include the provider's name, address, and telephone. (A credit card receipt without names or itemized purchases will not be accepted for reimbursement.)
4. This form and the receipts can submitted to benefits@kean.edu.

***Due to the expiration of collective bargaining agreements, this reimbursement program is currently NOT available to PBA, NJLESA, and NJSOLEA members.** The Vision Care Reimbursement Program is subject to change upon the ratification of new collective bargaining agreements.*

EMPLOYEE SECTION - TO BE COMPLETED BY THE EMPLOYEE

EMPLOYEE'S NAME _____

Employee's Kean ID # _____

EMPLOYEE'S HOME ADDRESS _____

(_____) _____ - _____
EMPLOYEE'S DAY TIME TELEPHONE NUMBER

This claim is for:

_____ SELF _____ DEPENDENT _____ SPOUSE

I certify that this bill represents a valid claim for reimbursement for Vision Care received by me or my eligible dependent named herein, and it is the only claim requested during the current contract period for me and/or the eligible dependent so named.

NAME OF DEPENDENT CHILD/SPOUSE _____

Exam	\$45.00	_____	Single Lenses	\$80.00	_____
			Bifocals	\$90.00	_____
			Trifocals	\$90.00	_____
			Contacts	\$80.00	_____

EMPLOYEE'S SIGNATURE _____ DATE _____

FOR OFFICE USE ONLY BELOW THIS LINE
Benefit Period is from **JULY 1, 2023 to JUNE 30, 2025**

_____ EYE EXAMINATION:	LENSES: Single / Bifocals / Trifocals / Contacts:
Amount of Claim _____	Amount of Claim _____
Sub-Total _____	Sub-Total _____
Prepared by: _____	Date _____
Manager's Authorization: _____	Date _____
Director's Authorization: _____	Date _____
	Total for this claim reimbursed to the employee: \$ _____

11-73510-5231

General Accounting Office Use Only
Approved by: _____ Date: _____