

# MONTCLAIR STATE UNIVERSITY

## VISION CARE REIMBURSEMENT PROGRAM

Full time employees and eligible dependents are entitled to receive one reimbursement for lenses purchased in a designated two (2) year contract period. Reimbursements may be up to \$35 for Eye Exam and Co-pay, up to \$40 in Single Vision lenses or contacts, and up to \$45 for Bifocals/Trifocal lenses or contacts by an Ophthalmologist or an Optometrist.

**The current reimbursement period runs from July 1, 2021 through June 30, 2022.**

*\*The Vision Care Reimbursement Program is subject to change upon the ratification of new collective bargaining agreements*

To receive reimbursement, please complete the form below and attach *an itemized receipt* before submitting request to the Benefits Department.

### **EMPLOYEE SECTION**

Employee's Name: \_\_\_\_\_ Union Type: \_\_\_\_\_  
Department: \_\_\_\_\_ Title: \_\_\_\_\_

**This application is for:** (Please Select)

☐ Self ☐ Spouse ☐ Child ☐ Civil Union/Domestic Partner

Name of Dependent Receiving Lenses: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Exam Date: \_\_\_\_\_ Exam Copay: \$ \_\_\_\_\_

Purchase Date: \_\_\_\_\_

**Type of Lenses:** (Please Select)

☐ Single Vision/Contacts ☐ Bifocal/Trifocal/Progressive/Contacts

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE:** Please include **original itemized receipts** from the vision care provider with employee's name, the services rendered and the amount paid for each service. These documents must be attached to this form and emailed to [hr-benefits@montclair.edu](mailto:hr-benefits@montclair.edu). Your claim will not be processed without a valid receipt.

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### **HR/BENEFITS USE ONLY**

\_\_\_\_\_**Approved** (Total) \$ \_\_\_\_\_ **Denied** (Reason): \_\_\_\_\_

\_\_\_\_\_**Exam/copay** \$ \_\_\_\_\_

\_\_\_\_\_**Lenses/ Contact (Single, Bifocal)** \$ \_\_\_\_\_

**Authorized Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_