WILLIAM PATERSON UNIVERSITY

Office of Payroll and Employee Benefits
Vision Care Program Reimbursement Request

Employee's Name: _____

Banner ID: _____

Type of qualified service(s) received for which you are requesting reimbursement:

☐ Eye Examination ☐ Lenses

Reimbursement of Vision Care Program services is requested for:

☐ Self

☐ Spouse:

Name: _____ Date of Birth: _____

☐ Dependent Child (ren):

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

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

_____ _____

Employee's Signature Date

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

Return the completed and signed form with receipts to the Payroll and Employee Benefits Office.

Payroll and Employee Benefits Use Only

Reimbursement: ____/____/____ Payroll Number: _____/_____

Amount Reimbursed: $_____ Services Reimbursed: ☐ Eye Examination ☐ Lenses