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, 2027.
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 be emailed to benefits@kean.edu.

* 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, 2025 to JUNE 30, 2027**

_____ EYE EXAMINATION:

Amount of Claim _____

Sub-Total _____

LENSES: Single / Bifocals / Trifocals / Contacts:

Amount of Claim _____

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: