Atlantic Cape Community College
Vision Care Reimbursement Form

Only one form accepted per <u>two-year reimbursement period</u>.
Please print neatly.

The vision care program is available once every two years for members and eligible dependents. Members shall be reimbursed for costs associated with vision exams and prescription eyewear up to $400.

Employee Name	**CWID #**
Address	Phone
City/State	Zip
Department	
Patient Name	Birthdate____/____/
Relationship to Employee Circle one: self spouse child dependent	Student ? Yes No
Total Submitted:	**Total Reimbursement:**

Employee Signature **Date** **Benefits Office** **Date**

Office Use Only

_____ Approved

_____ Disapproved reason:

Date of next Eligibility: _____

Receipt must accompany this form for reimbursement.

Submit completed form and all receipts to Human Resources for processing.

Vision form revised 07/2024