

Atlantic Cape Community College Vision Care Reimbursement Form

Only one form accepted per two-year reimbursement period.
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:				
<table><tr><td>Employee Signature</td><td>Date</td><td>Benefits Office</td><td>Date</td></tr></table>		Employee Signature	Date	Benefits Office	Date
Employee Signature	Date	Benefits Office	Date		
<p>Office Use Only</p> <p>_____ Approved</p> <p>_____ Disapproved reason:</p> <p>Date of next Eligibility: _____</p>					

Receipt must accompany this form for reimbursement.

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