St. Petersburg College

Medical Expense Reimbursement Plan VISION CLAIM FORM

| Address Social Security Number (required) Daytime phone number: area code + number Proof of vision expense for reimbursement: (Attach original bills or receipts to this form) Patient's name Relationship to employee of service Description of service Amount requested for reimbursement TOTAL | | | Reimburs | ement request | | | |
|---|--|--|--|--|--|--|--|
| Proof of vision expense for reimbursement: (Attach original bills or receipts to this form) Patient's name Relationship Date(s) Description of service Amount requested for reimbursement to employee of service TOTAL TO | Employee name | | | Date | | Amount Requested | |
| Proof of vision expense for reimbursement: (Attach original bills or receipts to this form) Patient's name Relationship to employee of service Description of service Amount requested for reimbursement of service reimbursement TOTAL have attached original receipts which show the payments for which I seek reimbursement under the Medical E ision Reimbursement Plan. If I, or my dependent, have requested payment for reimbursement of these expension of the reduced benefits plan, I have attached evidence of the extent to which such request has been denied. Imployee Eligibility: Employees may receive reimbursement based on length of employment with the college, ate since their last reimbursement. Reimbursement may be for any member of the family, but employees will creive up to \$175 total according to their length of service. Employees with less than ten years of service may receive no more than \$175 with a minimum of 12 months between dates of reimbursement. Employees with ten years of service may receive no more than \$175 with a minimum of 12 months between dates of reimbursement. MAXIMUM REIMBURSEMENT — this reimbursement, either 12 or 24 months ago, (based on above Employee Enteria), does not exceed the maximum amount of reimbursement that I am entitled to receive under this Plan. COORDINATION of BENEFITS — in the event that either 1 or my spouse have requested pay imbursement of these expenses from any other medical benefit plan, I am only requesting reimbursement expenses to the extent that they will not be paid for or reimbursed under any other plan. | Address | | | Social Secu | Social Security Number (required) | | |
| Patient's name Relationship to employee Re | City, State, Zip | | | Daytime pl | Daytime phone number: area code + number | | |
| to employee of service reimbursement TOTAL have attached original receipts which show the payments for which I seek reimbursement under the Medical E ision Reimbursement Plan. If I, or my dependent, have requested payment for reimbursement of these expens nother medical benefits plan, I have attached evidence of the extent to which such request has been denied. Imployee Eligibility: Employees may receive reimbursement based on length of employment with the college, ate since their last reimbursement. Reimbursement may be for any member of the family, but employees will receive up to \$175 total according to their length of service. Employees with less than ten years of service may omore than \$175 with a minimum of 24 months between dates of reimbursement. Employees with ten years of service may receive no more than \$175 with a minimum of 12 months between dates of reimbursement. **OMAXIMUM REIMBURSEMENT** — this reimbursement, when added to the sum of all other reimbursement ceived since my last date of reimbursement, either 12 or 24 months ago, (based on above Employee Eiteria), does not exceed the maximum amount of reimbursement that I am entitled to receive under this Plan. **COORDINATION of BENEFITS** — in the event that either I or my spouse have requested pay imbursement of these expenses from any other medical benefit plan, I am only requesting reimbursement of these expenses from any other medical benefit plan, I am only requesting reimbursement of these expenses from any other medical benefit plan, I am only requesting reimbursement of these expenses from any other medical benefit plan, I am only requesting reimbursement of these expenses from any other medical benefit plan, I am only requesting reimbursement of these expenses from any other medical benefit plan, I am only requesting reimbursement of these expenses from any other medical benefit plan, I am only requesting reimbursement of these expenses from any other medical benefit plan, I am only requesting reimbursement of these expenses from a | Proof of vision ex | xpense for reimbu | rsement: (Att | ach <i>original</i> bills o | r receipts t | o this form) | |
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Return completed form and original bills/receipts to: Custom Benefit Services ◆ PO BOX 4078, Ocala, FL 34478 ◆ 1-800-809-8161