St. Petersburg College

Medical Expense Reimbursement Plan

V I S I O N C L A I M F O R M

Reimbursement request

Employee name	**Date**	**Amount Requested**
Address	**Social Security Number (required)**	
City, State, Zip	**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**	**Date(s) of service**	**Description of service**	**Amount requested for reimbursement**
			TOTAL	$0.00

I have attached original receipts which show the payments for which I seek reimbursement under the Medical Expense Vision Reimbursement Plan. If I, or my dependent, have requested payment for reimbursement of these expenses under another medical benefits plan, I have attached evidence of the extent to which such request has been denied.

Employee Eligibility: Employees may receive reimbursement based on length of employment with the college, and the date since their last reimbursement. Reimbursement may be for any member of the family, but employees will only receive 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 24 months between dates of reimbursement. Employees with ten years or more of service may receive no more than $175 with a minimum of 12 months between dates of reimbursement.

Certification

◆ **MAXIMUM REIMBURSEMENT** – this reimbursement, when added to the sum of all other reimbursements I have received since my last date of reimbursement, either 12 or 24 months ago, (based on above Employee Eligibility criteria), 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 payment of reimbursement of these expenses from any other medical benefit plan, I am only requesting reimbursement of such expenses to the extent that they will not be paid for or reimbursed under any other plan.

I certify that: I have incurred refraction vision expenses, (vision exam, frames, repair of frames, lenses, contact lenses), and further certify that I am in compliance with the above statements.

_____ _____

Employee Signature *Date*

CUSTOM BENEFIT SERVICES USE ONLY:

Approved By	**Date**	**To Accounting**

Return completed form and original bills/receipts to:
Custom Benefit Services ◆ PO BOX 4078, Ocala, FL 34478 ◆ 1-800-809-8161