SPC St. Petersburg College
HUMAN RESOURCES

V I S I O N Reimbursement REQUEST FORM

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.

EMPLOYEE INFORMATION:

Name: _____ Department: _____

Position/Title: _____ Employee # _____

Work telephone #: _____ Other contact #: _____

Email address: _____ Address _____

Patient's Name	Relationship	Date of service to employee	Description of service	Amount requested for reimbursement
			TOTAL	

I have attached original receipts which show the payments for which I seek reimbursement under the Medical Benefit 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.

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 Employee Eligibility criteria), does not exceed the maximum amount of reimbursement that I am entitled to receive under this Plan.
COORDINATION of BENEFITS – if 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: Cornerstone Benefit, LLC
PO BOX 2553, Ocala, FL 34478 1-800-809-8161