KATONAH-LEWISBORO SCHOOL DISTRICT
VISION REIMBURSEMENT FORM

EMPLOYEE INFORMATION:

Employee Name: _____

Address: _____

_____

Building: ☐ DO ☐ IMES ☐ JJHS ☐ JJMS ☐ KES ☐ MPES ☐ TRANS

Bargaining Unit: ☐ Teacher ☐ Support Staff

VISION REIMBURSEMENT REQUEST:

Patient's Name: _____

Name of Provider: _____

Amount of Reimbursement Request: $_____

Does the patient have other vision coverage? ☐ Yes ☐ No If yes, please attach a copy of the explanation of benefit from other plan

CERTIFICATION FOR VISION REIMBURSEMENT:

I have attached the following information to this request:

- Detailed invoice
- Proof of payment (cancelled check, credit card receipt, statement from provider) A "PAID" stamp or handwritten note will not be accepted
- Explanation of benefit from insurance provider, if required

I certify that the expenses for which I am seeking reimbursement from the Vision Reimbursement Plan have been incurred by me or by an eligible dependent. I further certify that these expenses have not been reimbursed from any other vision coverage, including a flexible spending plan (FSA) and/or a health reimbursement account (HRA).

_____ _____

(Signature) (Date)

VERIFICATION OF REQUEST:

Amount: $_____ PO#: _____

Approved By: _____ Date: _____

Return completed form to the Payroll & Benefits Office