

ROWAN UNIVERSITY
STATE OF NEW JERSEY
HUMAN RESOURCES

VISION CARE PROGRAM REIMBURSEMENT

I certify that this bill represents a valid claim for reimbursement for vision care received by me/or my eligible dependent(s) and is the only claim requested during the eligibility period for me or my eligible dependent(s) so named. Please place a check for the services performed.

Employee _____

Eye Exam _____ Co-payment _____
Glasses/Contact Lenses _____
Bi/Trifocal Lenses _____

Dependent _____

Eye Exam _____ Co-payment _____
Glasses/Contact Lenses _____
Bi/Trifocal Lenses _____

Dependent _____

Eye Exam _____ Co-payment _____
Glasses/Contact Lenses _____
Bi/Trifocal Lenses _____

Print Employee Name _____

Employee Signature _____

Rowan ID # _____ Date _____

Phone Extension _____

Please Note: Original receipts must be attached to this certificate and submitted to Human Resources. Employee will only be reimbursed for one type of lense – glasses or contacts.

Human Resources:

Denied ____ At this time, you are ineligible for reimbursement. Our records indicate your last reimbursement was _____.

Sent to Payroll on: _____

Amount: _____

Approval: _____

Attachments _____
