Human Resources
GRAND TRAVERSE COUNTY

VISION PLAN REIMBURSEMENT REQUEST FORM

Each enrolled employee and qualified dependent are eligible for reimbursement for glasses or contact lenses according to the schedule following at least 24 months since the previous reimbursed service, after a $7.50 co-pay. Employees must have turned in an enrollment form within 30 days of hire, special enrollment period, or the annual open enrollment period.

Dependent children are covered until the end of the year in which they reach age 19 unless otherwise agreed in a labor agreement (currently FOP Health, FOP Central Records, COAM Dispatch Supervisors, Teamsters Dispatch).

The plan document shall govern all payment of claims and is available for review in the Human Resources Department.

To request reimbursement:

1. Complete this Vision Reimbursement Request Form. (One individual per form)
2. Attach a **paid, itemized** receipt which shows the dates of service, name of the person treated, item, and amount charged.
3. Submit the form and attachments to the Human Resources Department.
4. Reimbursement up to plan maximums will be included pre-tax on your paycheck within 30 days of receipt.
5. Note: Consider submitting an FSA Claim form (if eligible) for your co-pay.

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Employee Name: ______________________________ Last 4 Digits of SSN:________ FTE ________

Services were for:

____ Self

____ Spouse (Full name ___________________________

____ Dependent (Full name ___________________________date/of/birth__________ Age ______)

ITEM	DATE OF SERVICE	CHARGE	LESS $7.50 CO-PAY	AMOUNT PAID BY OTHER COVERAGE	BALANCE	PLAN WILL REIMBURSE UP TO	(H.R. USE ONLY) AMOUNT OF REIMBURSEMENT APPROVED
Contact lenses			- $7.50			$ 78	
Frames			❋			$ 35	
Lenses (single)			- $7.50			$ 43	
Lenses (bifocal)			- $7.50			$ 60 ($70/glass)	
Lenses (trifocal)			- $7.50			$ 90 ($100/glass)	

❋ NOTE: Less $7.50 Co-Pay here IF YOU ONLY PURCHASED FRAMES.

I certify that the charges for which I am requesting reimbursement have been paid in full and are not covered by any other form of vision coverage. Grand Traverse County has my permission to verify any information relating to this claim with the appropriate provider.

Signature__________________________________ Date___________

Eligibility approved: _________
Reviewed by: _______________

Amount approved: ___________

Payroll date: ________________

Processed by:________________