Vision Reimbursement Form

Employee Name: ___________________________ **Date:** ___________________

Employee ID #: ________________ **Phone:** __________________

Address: ____

Arc Mercer employees enrolled in the Agency's medical insurance plan as of 7/1/2023, are eligible to receive reimbursement of up to $200.00 towards the cost of an eye exam, glasses (frames/lenses) or contact lenses for the employee.

Valid receipts must be attached to this form at the time of submission.

Service to be reimbursed:

[ ] Eye Exam **[ ] Frame Purchase** **[ ] Lens Purchase** **[ ] Contact Lens Purchase**

Date(s) of Service or Purchase: ______________ **Total Cost:** ____________________

Employee:

_____________________________________ _____________________

Signature Date

Human Resources: ***(HR use)*** **Amount to be reimbursed**: _________________

_____________________________________ _____________________

Signature Date

Executive Director:

_____________________________________ _____________________

Signature Date

This is in effect from 7/1/2023 through 6/30/2024 and is subject to annual renewal. To be eligible employees must me actively enrolled in an Arc Mercer medical plan, actively employed and have dates of vision service between 7/1/2023 and 6/30/2024.