Stockton University
Vision Care Reimbursement Plan
Payroll Office

*** PLEASE ATTACH ORIGINAL RECEIPTS TO THIS FORM***

Employee Name ______________________________ Z# ______________________________

Department ______________________________ Phone# ______________________

Names	Relationship	Birth date	Exam/ Copay	Please Check One: Single Vision Lenses/Contacts	Bifocal or Trifocal Lenses

I hereby certify the accuracy of the Names and Birthdates of the above dependents.

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Employee's Signature

Employee submits an original receipt to the Payroll Office with this certification stating:

"I certify that this receipt represents a valid claim for reimbursement for Vision Care received by me or my eligible dependent named herein, and is the only claim requested during the current period for me or the eligible dependent so named."

______________________________ ______________________________

Employee's Signature Date