STOCKTON UNIVERSITY

Vision Care Reimbursement Plan
Payroll Office

PLEASE ATTACH ITEMIZED RECEIPTS TO THIS FORM AND SUBMIT TO THE PAYROLL OFFICE N-119

Employee Name _____ Z# _____

Department _____ Phone # _____

				SELECT ONE	
NAMES	**RELATIONSHIP**	**BIRTHDATE**	**EXAM COPAY**	**SINGLE VISION LENSES/CONTACTS**	**BIFOCAL/TRIFOCAL LENSES/CONTACTS**
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I hereby certify the accuracy of the names and birthdates of the above dependents. I certify that this itemized 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