

**ALLENTOWN SCHOOL DISTRICT  
Vision Care Reimbursement**

Employee Name:	
Social Security Number:	
Building:	

Position – Select One:	
05 Administrator	09 Paraprofessional
06 Teacher	10 Administrative Secretary
07 Secretary/Clerical	11 Security Officer
08 Custodian/Maintenance	FS Food Service
If you have circles 05, 06, 07, 08, or 10, complete the following: This reimbursement is for (select one): Self, spouse, or dependent age 16 or over Dependent under age 16 –list name and birth date below Name of dependent under 16 years Birth date of dependent under 16 years	

Fill in the amounts your paid below. Terms and amounts of reimbursement can be found in your bargaining unit agreement under “Vision Care”.

**BE SURE TO ADK YOUR DOCTOR AND/OR OPTICIAN FOR RECEIPTS THAT SHOW ITEMIZED COSTS FOR THE EXAMINATION, FRAMES, LENSES, AND TYPE OF LENSES.** Your reimbursement request will be returned to you if your receipts do not **CLEARLY** show itemized costs and type of lenses.

Reimbursement requests for examination, frames, and/or lenses must be submitted at the same time. Do not make separate applications, as only your first submission will be reimbursed, and any subsequent ones rejected.

	Amount you paid	For District Use Only
EXAMINATION	\$	
FRAMES	\$	
LENSES (select one)	\$	
Regular Bifocal Trifocal Aphakic Contacts (no frames reimbursement)		
		<b>Payment</b>
		<b>Approved:</b>
		<b>Date:</b>
		<b>Code: 1-5-5800-275-0- -06-09</b>

Return this form with attached receipts to Vision Care Reimbursement, Administration Center.  
(Phone 484-765-4017)

**Signature:**

**Date:**