CSU FULLERTON
Auxiliary Services Corporation
Serving the University in the Spirit of Excellence
2600 Nutwood Ave. Suite 275, Fullerton CA 92831 -3137

Vision Care Reimbursement Form
July 1, 2010 To June 30, 2012

Please attach original receipts to the back of this form.

I, ____________________________, certify that this bill represents a valid expense incurred by me or my eligible dependent whose name appears below for vision care services received. By signing this I am also acknowledging that I am aware that employees and eligible dependent (s) may be reimbursed up to **$400** each for every two-year period.

NAME OF DEPENDENT: ______________________________

RELATIONSHIP: ____________________________________

DATE OF BIRTH: ____________________________________

I also certify the accuracy of the name and date of birth of the above dependent.

Signature of Employee:	**Social Security # / CWID #**	**Date:**

For Human Resources & Payroll use ONLY:

Date of Employment: ________________

Date of Dependent (s) eligibility: _________________

Date V.C. last used: ____________________

Previous amount last used: ____________

Previous balance: ________________

Date of current bill: ______________

Amount of bill: _________________

Balance Remaining: ______________

Date Entered: ___________________

Entered by: ___________________

Eligible Reimbursement: ________________

Approved for payment by:

_________________________ ____________
Human Resources Manager Date

Note: All Vision Care expenses will be reimbursed on the following payroll check.