Questions about this form?
Contact: Kellie B.
kellieb@formulabenefits.com
(651) 686-0108 ext. 106

Return completed form to:
Formula Corporation
Vision Reimbursement
2919 Eagandale Blvd., Ste. 120
Eagan, MN 55121
Fax: 651-686-0513

Vision Reimbursement Claim Form

Important Information:

1. Use this form to request reimbursement for vision services. Each Participant is allotted $200 per Participant per Plan Year in addition to those provided, if any, as part of the Medical plan.
2. The maximum yearly reimbursement will not exceed $200 per calendar year for each eligible participant.
3. Expenses for vision services and eyewear can be claimed on this form. Only eligible expenses will be considered for reimbursement.
4. **In order to receive reimbursement, you must submit a receipt for the eligible expense showing your name.**

PERSONAL INFORMATION

Please fill out personal information below with the most current address, phone number, and email address. Please note that all information is updated accordingly and stored securely.

Name: ______________________________ Policy Holder: ______________________________

Relationship to Policy Holder: ☐ Self ☐ Dependent

Employer: ______________________________ Social Security Number: ______________________________

Birthdate: ______________________________ Primary Phone Number: ______________________________

Email Address: ______________________________

Address: ____
Address City, State, Zip Code

REIMBURSEMENT REQUEST

To claim reimbursement on eligible expenses:

- **Submit your receipt of the eligible expense showing your name.**
- **Examples of eligible expenses: Glasses, lenses, contact lenses, eye examinations, LASIK surgery, frames**

SIGNATURE

I hereby certify that the information shown above is true and correct. In addition, I certify that the person listed above is eligible to be covered under the Plan.

______________________________ ______________________________
Signature Date