# SOUTHERN EDUCATIONAL SERVICES COOPERATIVE
## Request for Optical Reimbursement

Date of Request: _____

Employee: _____ ID #: _____

Address: _____ City: _____ Zip: _____

Patient: _____ Self_____ Spouse _____ Child_____

Age if Patient is Dependent Child: _____

Please complete employee information and attach an itemized statement with a paid receipt for the examination of glasses or contact lenses.

***Maximum reimbursement benefits paid for optical insurance is $350 every other fiscal year per employee and eligible dependents.***

Return to: Michael Click
Southern Educational Services Cooperative
214 N. Kanawha Street
Beckley, WV 25801

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## Official Use Only

Date(s) of Service: _____

Receipt Amount(s): $_____

Amount Approved
For Reimbursement: $_____

***OK TO PAY***

By: Date: _____

Vendor # _____

Budget
Code: _____

Approved for Payment by: