VISION EXPENSES
JULY 1, 2023 – JUNE 30, 2024

As you are aware, the Township of Ocean Board of Education offers a Vision Expense Reimbursement to their employees.

- To participate an employee must work 30 hours or more per week and be eligible for health benefits.

- Reimbursement rate - $150.00 per family during the plan year of

July 1, 2023 – June 30, 2024

The Township of Ocean Board of Education Vision Reimbursement Plan Year runs from July 1, 2023 through June 30, 2024. The deadline to submit bills for expenses incurred during this plan year will be September 28, 2024.

- A form to apply for the $150.00 reimbursement has been attached for your convenience.

- How to obtain the $150.00:

1) Complete the claim form
2) Attach the proper receipt/receipts from your service provider to the form. A proper receipt must clearly show the date of service, provider's name and address, the name of the person receiving the service, and the total amount of the expense.
   Please note - Credit card receipts and canceled checks are not acceptable receipts.
3) Employees may return the completed form to Mrs. Porbansky in the Personnel Office, fax the claim to OCA at 609-514-0111, email the claim to claims@oca125.com , or mail the completed forms directly to:

OCA
3705 Quakerbridge Road, Suite 216
Mercerville, NJ 08619

Any questions regarding this plan, kindly contact Mrs. Porbansky at 732-531-5600 Ext. 3005. Thank you!

JULY 2023/JUNE 2024
TOWNSHIP OF OCEAN BOARD OF EDUCATION
VISION REIMBURSEMENT REQUEST FORM

Employee Name:_____ **SS#:**_____

Address:_____**City:**_____**State:**_____**Zip:**_____

Home #: (____)_____**Work #: (____)**_____**Email Address:**_____

☐ ***Check here if submitting a Change of Address***

Complete the information below for medical expenses incurred by you, your spouse, or other eligible dependents for which you request reimbursement under TOWNSHIP OF OCEAN BOARD OF EDUCATION Health Reimbursement Account. *Be sure to provide all information requested in each "Expense" column as outlined in the column labeled "Example." If the form is incomplete, it will be returned to you.* Print or type the information requested. Then date and sign the form. **Send this form along with the third-party documentation substantiating your claim(s) as identified in the Summary Plan Description/Plan Information Appendix to your service provider OCA, 3705 Quakerbridge Road, Suite 216, Mercerville, NJ 08619, or by email at claims@oca125.com, or fax directly to (609) 514-0111.**

	EXAMPLE	Expense #1	Expense #2	Expense #3	Expense #4	Expense #5
Date Medical Service Actually was Provided	07/01/2023					
Name of Person Receiving Medical Service Relation to Employee (check one)	Fred Jones ☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent
Type of Service	Deductible					
Total Expense	$150.00					
Amount Reimbursed Previously for this expense from another source (if any)	$0.00					
Reimbursement Requested	$150.00	$	$	$	$	$

Total Reimbursement Being Requested $_____

To the best of my knowledge and belief, my statement(s) in this reimbursement form is complete and true. I certify that I or my eligible family member(s) have received the service(s) described above on the date(s) indicated and that the expense(s) qualifies as an **eligible medical expense(s)** under the Plan. I also certify that I have not been reimbursed previously under TOWNSHIP OF OCEAN BOARD OF EDUCATION Health Reimbursement Account or any other health plan, nor will I seek reimbursement for this expense(s) elsewhere. I understand that this expense(s) for which I receive reimbursement under this Plan may not be used to claim any federal income tax deduction or credit.

_____ _____

Employee Signature Date