

Utah Local Governments Trust
55 South Highway 89, North Salt Lake, Utah 84054-2504
Vision Plan Reimbursement Form

I. EMPLOYEE INFORMATION SECTION

Employee Name	Social Security Number
Address	Daytime Phone Number

II. VISION EXAMINATION REIMBURSEMENT SECTION (PAYABLE EVERY 12 MONTHS)*

DATE OF SERVICE	PATIENT NAME	PROVIDER NAME	COST OF EXAM
			\$
			\$
			\$
TOTAL COST OF VISION EXAM			\$

III. FRAMES & LENSES - In lieu of contacts (PAYABLE EVERY 24 MONTHS)*

DATE OF SERVICE	PATIENT NAME	PROVIDER NAME	COST OF GLASSES
			\$
			\$
			\$
TOTAL COST OF FRAMES AND/OR LENSES			\$

IV. CONTACT LENSES - In lieu of frames & lenses (PAYABLE EVERY 24 MONTHS)*

DATE OF SERVICE	PATIENT NAME	PROVIDER NAME	COST OF CONTACTS
			\$
			\$
			\$
TOTAL COST OF CONTACT LENSES			\$

V. TOTAL REIMBURSEMENT \$ _____

VI. SIGNATURE _____

DATE _____

***NOTE:** Please attach supporting documentation (receipts, billing statement, etc.), a separate form for each receipt is not necessary. Please combine all eligible expenses on one form. Claims will not be processed without completed reimbursement form and supporting documentation. Supporting documentation will not be returned, therefore be sure to keep copies of these expenses for your records.