TAYLOR SCHOOL DISTRICT
TFT VISION REIMBURSMENT PROGRAM APPLICATION

Please Print

Employee Last Name		Legal First Name		Middle Initial
Address	**Apt.**	**City**	**State**	**Zip**

Last 4 of S.S. #	Employee #	BIRTHDATE MM/DD/YEAR	
			☐ Male ☐ Female

List dependents to be included for vision program
***Legal First Name and Middle Initial Only – Last name if different from yours.**

NAME and INITIAL	BIRTHDATE MM/DD/YEAR	SEX	RELATIONSHIP

Signature

Date

TAYLOR SCHOOL DISTRICT
VISION REIMBURSEMENT FORM

EMPLOYEE NAME: ______________________________

EMPLOYEE #: ____________ Will NOT be processed without your employee #

BUILDING LOCATION: ____________

ADDRESS: ______________________________

CITY: ____________ **STATE:** _____ **ZIP:** ________

Is this claim for a dependent? Y or N (circle one)

If yes, name of dependent: ______________________________

Name of Vision Care Provider: ______________________________

Service Rendered: ______________________________

Date of Service: ____________ **Amount $** ____________

Eye examinations, eyeglass frames and lenses and/or multiple contact lenses to correct visual acuity once in any twenty-four (24) month period.

Maximum allowable expense shall include any combination of exam, lenses, frames or contact lenses:

Single Vision Benefit	**$160.00**
Bifocal Vision Benefit	**$190.00**
Trifocal Vision Benefit	**$200.00**
Lenticular Vision Benefit	**$235.00**

______________________________ ____________

Employee Signature **Date**

PLEASE COMPLETE A DIFFERENT FORM FOR EACH PERSON RECEIVING TREATMENT
RECEIPTS MUST BE ATTACHED FOR REIMBURSEMENT

Return completed form and receipts to:
Taylor School District
Insurance Department
23033 Northline Rd.
Taylor MI, 48180