St. Johns County School District
Vision Benefit Plan

Request for Reimbursement Claim Form

Important Vision Plan Reminder: Requests for reimbursement must be submitted within six (6) months from the date of service for your vision claim to be reimbursed.

Participant Information			
Employer Name St. Johns County School District	**Group #** 463	**Today's Date**	**Daytime Phone Number**
Employee Name	**Employee ID#** or **Last 4 digits of SSN**		**Email Address**
Dependent Name (if claim is for Dependent)	**Dependent Date of Birth**		
Employee Mailing Address			

Summary of Vision Plan Benefits

Covered Vision Services	Vision Benefit
Eye Exam Limited to one (1) exam each Calendar Year.	Plan pays 100%; maximum reimbursement of $65.
Contact Lenses or Prescription Eyeglasses / Frames Lenses are limited to once every Calendar Year; Frames are limited to once every Calendar Year.	Plan pays 100%, maximum reimbursement of $200; Unused benefit from the prior plan year may be carried over for a maximum reimbursement of $400.

Steps to request a vision plan reimbursement:

Step 1. Complete this form and attach an itemized bill or payment receipt from your vision provider. Be sure it includes the type of service received.

Step 2. You have several options for submitting your vision reimbursement requests:

- **Fax** your request to **1(407)786-2999**.
- **Mail** your request to:

  Preferred Benefit Administrators
  PO Box 916188
  Longwood, FL 32791-6188

Questions regarding your vision coverage or status of reimbursement should be directed to:

Preferred Benefit Administrators
Toll-free: (888) 524-2777
www.PreferredTPA.com