COMPUTER/VDT OPERATOR EYE EXAM and LENS REIMBURSEMENT

NOTE: For Eye Exam and Lens reimbursement, six items are required:

1) At least one year has passed since date of last eye exam.
2) *Section "A":* MSEA Bargaining Unit Employee or Confidential Employee certifies qualification; Supervisor confirms.
3) *Section "B":* Employee completes appropriate sections and attaches original bill(s) and receipts
4) *Section "C"*: Human Resources approves form and completes Exam/Lenses payment codes.
5) *Page 2*: (Certificate Authorizing Release of Information) Employee completes top and Eye Exam Report completed by doctor.
6) *A statement from the provider indicating what was paid for by the employee.*
Forward documents to: *Heather.Grover@maine.gov or fax to 207-287-2216.*

A. *EMPLOYEE INFORMATION and SUPERVISORY APPROVAL*

Name: _____ Job Title: _____ Agency: _____

I certify I am in an MSEA bargaining unit and spend at least 80% of my time operating a Video Display Terminal-
OR –
I am a Confidential employee and spend a significant number of hours operating a Video Display Terminal.

Employee Signature:_____**Date:**_____

The immediate supervisor confirms that this employee spends at least 80% of time operating VDT in accordance with the Computer /VDT Operators' Article of the applicable MSEA collective bargaining agreement ***OR*** *a significant number of hours if Confidential.*

Supervisor: _____ ***Date***_____ ***Print Name***_____

Authorized Agency Official: _____ ***Date***_____ ***Print Name***_____

B. *REIMBURSEMENT AMOUNT (Employee completes this section)*

NOTE: Contract language provides for reimbursement of the cost of the annual exam not covered by insurance (for annual eye exam only—not other appointments like lens fittings, etc) and either $100 (single vision) or $150 (bifocal, trifocal or progressive) for corrective lenses or glasses.

		Amount	Notes/Maximums
Exam:	Amount not covered by Insurance	$	(co-pay or cost of annual eye exam not covered by insurance)
Lenses:	(Single Rx)	$	($100 Maximum)
--or--	(Bifocal, Trifocal or Progressive)	$	($150 Maximum)
Total Reimbursement to Employee:		$	
Employee Mailing Address:			

C. *AGENCY APPROVAL & ACCOUNTING*

_____ _____ _____
Human Resource Signature **Print Name and Title** **Date**

Required Codes for processing payment:

	Fund	*Agency*	*Report Org*	*App Unit*	*C&O*	*(Optional) Rep Cat*	*(Optional) Project*
Exam:							
Lenses:							

Revised: 03/19/2018

CERTIFICATE AUTHORIZING RELEASE OF INFORMATION

(To be completed by Employee)

TO _____ **Telephone No.** _____

(Name of Eye Care Provider/Physician)

_____

Address

EMPLOYEE
(print name) _____

AGENCY/DEPT _____
ADDRESS _____

I, _____hereby grant the above-mentioned agency/department and its duly
(Name of Employee)
appointed representative _____ to obtain, examine, copy or
(Human Resources Staff)
reproduce in any manner, any and all information, records, documents, or reports in your possession relating to this eye exam or glasses/contact lenses reimbursement.

_____ _____
Employee Signature Date

STATE OF MAINE
VIDEO DISPLAY TERMINAL OPERATOR
EYE CARE PROVIDER STATEMENT/EYE EXAM REPORT

(To be completed by Examining Provider)

EMPLOYEE NAME _____

I have examined the above-named individual and recommend that:

The individual should have: single vision lenses _____

bifocal/trifocal/progressive lenses: _____

Date of This Examination _____ _____
Examiner's Name (Please print)

Date of Previous Examination _____ _____
Examiner's Signature