

Application for Reimbursement of Co-Payments for participants in the NIOSH Health Assessment at the Bennington State Office Building (rev. 10/13/2006)

Employee name: _____ Department: _____

Social Security Number: _____ (necessary to process VISION voucher)

By submitting the application I hereby certify that:

- 1) I took part in the NIOSH assessment at the Bennington State Office Building, AND
- 2) I visited a private health care provider for the purposes of following up or discussing the results of that assessment, AND
- 3) I have not been reimbursed for the medical insurance co-payments, co-insurance, or deductibles associated with this visit by any other health care plan, from my own flexible spending account, or from any other source, AND
- 4) If the State of Vermont reimburses me for the medical insurance co-payments, co-insurance, or deductibles associated with this visit, I will not seek reimbursement for these expenses from any other health care plan, from my own flexible spending account, or from any other source.

I am requesting reimbursement of the following amount: _____.

I have attached the following documentation of my actual costs for the above visit (check one):

- Receipt for my co-payment issued by the health care provider
 Explanation of Benefits (EOB) issued by CIGNA

Employee signature

Date

Departmental Approval by:

Signature/Title

Date