

# Health & Wellness



**NY Power  
Authority**

## APPLICATION FOR REIMBURSEMENT OF EYE EXAMINATION FOR NYPA IBEW BARGAINING UNIT EMPLOYEES

TO: Human Resources Facility Manager

DATE: \_\_\_\_\_

FROM: \_\_\_\_\_  
Employee Name (Print)

DATE OF LAST EXAM: \_\_\_\_\_

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

SITE FINANCE MANAGER  
SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**G/L ACCT# 631700  
COST CTR H129**

A bill signed by a licensed ophthalmologist or optometrist including the employee's name,  
date of service, cost, and description of services must be attached.

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TO: SENIOR ACCOUNTANT/PAYROLL

ACCOUNTING SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

AMOUNT TO BE REIMBURSED: \_\_\_\_\_

Employee to be reimbursed through payroll.