Public Schools of the Tarrytowns

OPTICAL REIMBURSEMENT CLAIM FORM

EMPLOYEE: _____ **Date:** _____

ADDRESS: _____

_____

TRANSACTION DATE	TYPE OF PURCHASE *(Attach all itemized original receipts)*	TAT , Confidential	CSEA Unit I	CSEA Unit II	EXPENSE AMOUNT
				TOTALS:	

TAT / Confidential

$200 Per Claim

$200 Maximum Claim Per Year

CSEA Unit I

$100 Per Claim

$200 Maximum Claim Per Year

CSEA Unit II

$200 Per Claim

$200 Maximum Claim Per Year

EMPLOYEE SIGNATURE: _____

FOR BENEFITS OFFICE USE ONLY

Budget Code: A 9089-802-00-0000

BENEFITS OFFICE APPROVAL: _____ **Date:** _____

Claim 1 of 2: _____

Claim 2 of 2: _____