C.O.P. E.S.D.
Personal Frame Reimbursement Form

Employee Name	______________________	Work Phone	______________________
Address	______________________	Home Phone	______________________
Address	______________________	Position	______________________
Acct #	______________________	Amount	______________________
Acct #	______________________	Amount	______________________

*Amount paid by employee equals total cost of frame, less amount paid by insurance

Date	*Amount Paid by Employee	For Office Use Only

READ CAREFULLY

1.) Claims must be submitted within 6 months of frame purchase (checks will be issued 3 weeks after submission)
2.) Attach original receipt containing employee name and cost of frame, itemized separately from cost of lenses and exam
3.) **Personal Frame Reimbursement Form available on COP website**

Submit Reimbursement Form to:

COP Educational Service District
Attention: Bridget Merchant
6065 Learning Lane
Indian River, MI 49749

______________________ Employee Signature ______________________ Date

______________________ Supervisor Approval ______________________ Date

For Office Use Only	Date Received	/ /

Effective July 1, 2009
Revised Dec. 1, 2020