LOCAL 300 – SEIU – AFL-CIO
WELFARE FUND
253 West 35th Street, 12th Floor
New York, NY 10001
(212) 505-5050

VISION CARE CLAIM REIMBURSEMENT FORM

SEND COMPLETED FORMS TO: LOCAL 300 WELFARE FUND, 253 West 35th street, 12th floor, New York, New York 10001 (212) 505-5050

MEMBER PLEASE COMPLETE 1-5

Claim No. _____

1. Member's Full Name _____ Soc. Sec. # ____-____-____
2. Member's Address _____ City _____ State _____

   Zip Code _____ Tel. # _____

Dependent Children are covered up to age 19, or up to age 25 if they are full time students

3. If claim is for a DEPENDENT, give name _____ Relation _____ D.O.B. _____
4. Present Place of Employment _____ Tel. # _____
5. I understand that this form is for reimbursement purposes to members of LOCAL 300 WELFARE FUND.

   Date _____ 19 _____ Member's Signature _____

In order to process this claim, a copy of the paid bill must be attached

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TO BE COMPLETED BY OPTOMETRIST, OPTICIAN OR OPHTHALMOLOGIST

Patient's Name _____

Check one or more:

o Examination	$ _____
o Single Vision Lens	_____
o Bifocal Vision Lens	_____
o Contact Lens	_____
o Other	_____
Total Charges	$ _____

Date _____ Signed _____ License No. _____

Name of Optical Center: _____

Address _____ Tel. No. _____

Check One: Ophthalmologist _____ Optician _____ Optometrist _____