LOCAL 300 – SEIU – AFL-CIO
WELFARE FUND
1040 Avenue of the Americas, 24th Floor
New York, NY 10018
(212) 505-5050

VISION CARE CLAIM REIMBURSEMENT FORM

SEND COMPLETED FORMS TO: LOCAL 300 WELFARE FUND, 1040 Avenue of the Americas, 24th floor, New York, New York 10018 (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 ________