MANHASSET EDUCATION ASSOCIATION TRUST FUND
VISION REIMBURSEMENT FORM

MEMBER PLEASE PRINT

Member's Last Name	Member's First Name		Member's ID No.
Full Mailing Address No. and Street		Apt. No.	Home Telephone #
City State Zip		Is The Above Address Different From Your Last Claim Filed? YES ☐ NO ☐	Is This The First Claim Filed By You? YES ☐ NO ☐
Patient's Last Name		Patient's First Name	Patient's Date of Birth Mo. Day Year
Spouse's Last Name	First Name Initial		Spouse's Social Security No.
Employer	Work Telephone No.		Member's Date of Birth Mo. Day Year
Is Your Spouse Employed? YES ☐ NO ☐	If "YES", give name and address of your Spouse's employer:		
Are Benefits Available From Any Other Group Insurance Carrier For This Patient? YES ☐ NO ☐	If "YES", give name of carrier, plus name and I.D. No. of subscriber		
I certify that the information given is correct and authorize release of any information necessary to process this claim. Benefits are not available under any other Group Plan except as indicated above.	Benefits are payable to Member only Member Sign here_____Date_____		

VISION BENEFITS

Member (reimbursement up to $250)

Spouse/Dependents (reimbursement up to $150)

Attach copy of provider's bill to this claim form showing itemized services, fees, and date.

Mail completed forms to:

MEA TRUST FUND
C/O DANIEL H. COOK ASSOCIATES, INC.
1040 Avenue of the Americas, 24th Fl
NEW YORK, NY 10018
(212) 505-5050