MANHASSET EDUCATION ASSOCIATION TRUST FUND

MAIL COMPLETED FORM TO:

Manhasset Education Association Trust Fund
253 WEST 35TH STREET, 12TH FLOOR
NEW YORK, NEW YORK 10001-1907
(212) 505-5050

PATIENT'S NAME	RELATIONSHIP TO PARTICIPANT: SELF / SPOUSE / CHILD / OTHER	SEX: M / F	PATIENT BIRTHDATE: MO. / DAY / YEAR
PARTICIPANT'S (MEMBER'S) LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NO.
FULL MAILING ADDRESS	NO. AND STREET	APT. NO.	EMPLOYEE'S SCHOOL BUILDING
CITY	STATE	ZIP CODE	HOME TELEPHONE NO. (INCLUDING AREA CODE) ( )
EMPLOYER	WORK TELEPHONE NO. (INCL. AREA CODE) ( )	IS THE ABOVE ADDRESS DIFFERENT FROM YOUR LAST CLAIM FILED? ☐ YES ☐ NO	IS THE FIRST CLAIM FILED BY YOU? ☐ YES ☐ NO
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. IF YES, SPOUSE BIRTHDATE ______ MONTH ______ DAY		MEMBER'S BIRTHDATE ______ MONTH ______ DAY

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 __________

Check ☑ the benefit(s) for which you are applying:

VISION BENEFITS (Member, Spouse and Eligible Dependent Children)

Services Rendered:

- ☐ One set of lenses, including contact lenses during a 12 month period.
- ☐ One set of frames during a 24 month period.
- ☐ Vertification of fitting.
- ☐ Ophthalmic materials required for fitting and later evaluation of eyeglasses.
- ☐ History, evaluations and examinations (including examinations for disease or pathological abnormalities) once during each 12 month period.

Attach copy of provider's bill showing itemized services, fees and date.

HEARING AID BENEFITS (Member, Spouse and Eligible Dependent Children)

Services Rendered:

- ☐ Hearing analysis, tests, or evaluations performed by a physician, otologist, or audiologist
- ☐ Hearing aid appliances prescribed by a physician.
- ☐ Cost and installation of a hearing aid after the date of a written recommendation made by a physician or otologist.

Attach copy of provider's bill showing itemized services, fees and date.