United Teachers of Seaford Trust Fund
Local 1780

RETURN THIS FORM TO
United Teachers of Seaford Trust Fund
c/o Daniel H. Cook Associates
253 West 35th Street, 12th Floor
New York, NY 10001
((212) 505-5050

MEMBER NAME: (print last name first)	Sex (circle one) M F	MEMBER=SOCIAL SECURITY NUMBER XXXX | XX |	MEMBER DATE OF BIRTH MO. DY. YR.

HOME ADDRESS: Number and Street APT.		HOME PHONE (include area code)
CITY STATE ZIP	PAYROLL TITLE	EMPLOYER PHONE (include area code)

I certify that the information given is correct and authorize release of any information necessary to process this claim.

MEMBER SIGN HERE ________________________________ Date __________

Benefits are payable to member only

Optical (Member Only)

- ☐ This benefit provides for **out-of-network** optical expenses and services up to $350.00 per calendar year.

Amount Requested $ __________

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Co-Pay Benefit (Member Only)

- ☐ The Variable benefit provides you with a supplemental payment of up to $350.00 per member per calendar year to assist in paying certain out-of-pocket expenses.

Amount Requested $ __________

You may claim your co-pay benefit at any point during the year at which you reach your benefit maximum. If you choose to wait, your claim MUST be submitted in the first quarter following the year charges were incurred in order to be eligible for coverage. (Example: Covered expenses incurred from 1/1/17 through 12/31/17 can be claimed between 1/1/18 and 3/31/18).

Please include copies of all bills and/or explanation of benefits denoting your out-of-pocket expense.