Manhasset Education Association Trust Fund
VISION/HEARING AID BENEFITCLAIM FORM

MEMBER PLEASE PRINT

Member's Last Name	Member's First Name		Member's Social Security 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 MM / DD / YY
Spouse's Last Name	First Name Initial		Spouse's Social Security No.
Employer	Work Telephone No.		Member's Birthdate 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_____		

Mark {X} the benefit(s) for which you are applying:

VISION BENEFITS
Member (reimbursement up to $250)
Spouse/Dependents (reimbursement up to $150)

☐ **One set of lenses, including contact lenses during a 12 month period**

☐ **One Set of Frames during a 24 month period**

☐ **Verification of fitting**

☐ **Ophthalmic materials required for fitting and later evaluation of eyeglasses**

☐ **History, evaluations and examinations (including examinations for disease of pathological abnormalities once during each 12 month period)**

HEARING AID BENEFITS (MEMBER, SPOUSE, AND ELIGIBLE DEPENDENT CHILDREN)

☐ **Hearing Analysis, Tests, or evaluations performed by a physician, otologist, or audiologist**

☐ **Hearing aid appliances prescribed by a physician**

☐ **Cost and installation of hearing aid after the date of written recommendation made by a physician or otologist**

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.253 WEST 35TH STREET, 12TH FLOOR NEW YORK, NY 10001
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