LOCAL 7 WELFARE FUND

C/O Daniel H. Cook Associates, Inc.
253 West 35th Street, 12th Floor New York, NY 10001
(212) 505-5050

Optical Reimbursement Form

Member's Last Name	Member's First Name		Member's Social Security No.	
Member's Mailing Address		Apt. No.	Member's Date of Birth MM / DD / YY	
City	State	Zip	Active ☐	Retired ☐
Patient's Last Name	Patient's First Name		Patient's Date of Birth MM / DD / YY	
E-mail Address	Telephone No.	Date of Service MM / DD / YY	Relationship to Member	

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

Member's Signature: _____Date: _____

TOTAL AMOUNT : _____

Attach Copies of Original Receipts to This Claim Form

Please attach itemized receipt that contains: Patient's Name, Date of Service, the prescription and proof of payment.

Mail completed forms to:

Local 7 Welfare Fund
C/O Daniel H. Cook Associates, Inc.
253 West 35TH Street, 12TH Floor
New York, NY 10001
(212) 505-5050

The State of New York requires this statement to appear on all claims forms:

"Any person who knowingly and with the intent to defraud any insurance company or other persons files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation." Fraudulent insurance acts are a crime in all states, and additionally a felony in several states.