SOMERS FACULTY ASSOCIATION BENEFIT TRUST FUND
VISION CLAIM FORM

1. EMPLOYEE'S NAME		2. LAST 4 DIGITS OF Social Security Number	
3. EMPLOYEE'S MAILING ADDRESS (CITY) (STATE OR PROVINCE) (ZIP CODE)			
4. PATIENT NAME (IF A DEPENDENT)	5. RELATOINSHIP TO EMPLOYEE	6. BIRTH DATE	7. TELEPHONE NUMBER
8. DOES PATIENT HAVE OTHER HEALTH COVERAGE (IF YES, PLEASE IDENTIFY) YES__ NO_			

Maximum Benefit: $500.00

- Services must be incurred between July 1, 2026 and June 30, 2027.
- All claims for the fiscal year ending June 30, 2027 must be received by Daniel H. Cook by September 30, 2027.

Name of Member Or Dependent	Date of Service	Doctor Statement & Receipt Attached	Amount of Vision Benefits
_____	_____	_____	$_____
_____	_____	_____	$_____

- Vision expenses must be incurred by you, your spouse, and/or eligible dependent children and not reimbursed by any other dental or vision plan.
- Please include a copy of the Doctor's statement and/or receipt.
- Providers may submit an HCFA form if submitting this claim on behalf of a member.
- Services must be incurred between July 1, 2026 and June 30, 2027.
- All claims must be received at Daniel H. Cook by September 30, 2027.
- Claims will be processed and mailed in 2-3 weeks from receipt of submission.

If you have any questions regarding your claim, please call (212) 505-5050

_____ _____

Signature **Date**

Claims can be submitted in one of two ways:

Claim forms can be mailed to this address:

SOMERS FACULTY ASSOC. TRUST FUND
C/O Daniel H. Cook Associates, Inc.
1040 Avenue of the Americas, 24th Floor
New York, NY
(212) 505-5050

Claims can be emailed to:
intake@dhcook.com

Please note: All claim forms and attachments must be submitted in PDF format.