OPTICAL REIMBURSEMENT CLAIM FORM

Mail this form with an itemized bill(s) to:

SERVICE EMPLOYEES BENEFIT FUND
P. O. Box 1240, Syracuse, NY 13201
(315) 218-6513 • (855) 835-9720

Or you may fax it to (315) 701-0686

REIMBURSEMENT ELECTION: (check one) ☐ $60.00 (every 12 months) **OR** ☐ $120.00 (every 24 months)

A. MEMBER INFORMATION – Sections A and D must be completed. Section B must be completed only if patient is not the member.

Member's First Name Middle Initial Last Name	Date of Birth _____/_____/_____	Social Security Number _____/_____/_____
Member's Address Street City State Zip Code		Employer

B. PATIENT INFORMATION – Complete only if patient is NOT the member.

Patient's First Name Middle Initial Last Name	Patient's relationship to member: ☐ Spouse ☐ Child ☐ Other (Specify) _____	Date of Birth ____/____/____

C. ASSIGNMENT OF BENEFITS (Sign here ONLY if you want the money to be sent to the provider.)

I authorize payment of benefits, otherwise payable to me, to my eye care provider for services rendered indicated on the enclosed bill(s). I understand that I am financially responsible to the eye care provider for charges not covered by my Optical Plan.

_____ _____
Member's Signature Date

D. MEMBER'S SIGNATURE – Member must sign all claims.

Certification: I certify that the above information is complete, true and correct. I understand that this claim cannot be processed without the member's signature.

_____ _____
Member's Signature **Date**