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 • Fax (315) 701-0686

REIMBURSEMENT ELECTION: (check one) ☐ $60.00 (per year) **OR** ☐ $120.00 (every two years)

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:	Date of Birth
			☐ Spouse ☐ Child ☐ Other (Specify) ________________	____/____/____

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**