LOCAL UNION 373 HEALTH & WELFARE FUND
OPTICAL REIMBURSEMENT APPLICATION
PO BOX 58 MOUNTAINVILLE, NY 10953 (PH) 845-534-9522

MEMBER # _____ **CLAIM #**_____

To be eligible for this benefit, you must be currently insured by the Health & Welfare Plan of Local Union 373. You, or any member of your immediate family is eligible for reimbursement for optical charges, including examinations, prescription eyeglasses or contact lenses. Dependents shall include your lawful spouse and dependent children up to their 26th birthday. You are eligible for a reimbursement of up to **$100.00 every two consecutive calendar years beginning with the odd numbered years** for yourself and an additional amount for each eligible dependent. Benefits are not assignable. Payment will only be made to you. This claim form must be completed fully, and a statement or receipt must show: Name of the patient; name of the provider (Doctor, Optometrist, Optician); the date the charge was incurred and that the charge was paid. **Do not** submit cash register receipts or canceled checks. They will be returned. Each charge must be accompanied by a completed form.

Insured's Name _____ SS # _____

Address: _____

Patient's Name _____

If dependent, relationship to member _____

This is a claim for reimbursement for: (check one)

Examination _____ Prescription Eyeglasses _____ Contact Lenses _____

Providers Name _____

Provider's Address _____

Provider's Phone # _____ Date of Service _____

Charges $_____

I, the undersigned, declare that the above claim is for myself, or an eligible dependent member of my family, and authorize the Trustees of the Health & Welfare Plan of Local Union 373 to verify the claim as may be required.

_____ _____

Signature **Date**

_____I will pick my check up at the Fund Office _____Please mail my check _____Direct Deposit