FARMINGDALE FEDERATION OF TEACHERS BENEFIT FUND
100 BROADHOLLOW ROAD - SUITE 104, FARMINGDALE, NY 11735-4813
(631) 249-0773

MEMBER REIMBURSEMENT VISION CARE FORM
NOT FOR USE BY PROVIDER

_____ _____
Member's Name Social Security #

Home Address: Street City State Zip Code

_____ _____ _____
Patient's Name Date of Birth Relationship

The Benefit Fund will reimburse each member and eligible dependents to a maximum of $250 per family in each calendar year for vision care services. Please attach a detailed paid receipt* from your vision care provider that includes the patient's name, services rendered, dates of services, and the total amount of charges.

***NO CASH REGISTER RECEIPTS, BILLING STATEMENTS, INTERNET, EMAIL OR CREDIT CARD CHARGE RECEIPTS WILL BE ACCEPTED. This claim form, with attached paid receipt, should be submitted within 60 days of the date these services were rendered.**

THE DEADLINE FOR SUBMISSION OF CLAIMS IS FEBRUARY 28 OF THE FOLLOWING YEAR.

PLEASE CHECK THE APPROPRIATE CATEGORY AND INSERT REQUIRED INFORMATION.

SERVICE	DATE	AMOUNT PAID
_____ Eye Examination	_____ Month Day Year	$_____
_____ Eyeglasses/Contacts	_____ Month Day Year	$_____
_____ Other: (Specify) _____	_____ Month Day Year	$_____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR FUND, FILES A 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.

I wish to be reimbursed for my vision care expenses and have attached the required receipt.

_____ _____
Member's Signature **Date**

THE DEADLINE FOR SUBMISSION OF CLAIMS IS FEBRUARY 28 OF THE FOLLOWING YEAR.

TO BE COMPLETED BY FFT BENEFIT FUND OFFICE ONLY

Approved by: _____ Amount Submitted: _____

Date Processed: _____ Amount Reimbursed: _____

Check Number: _____ Amount Not Covered: _____