SUPPLEMENTAL BENEFITS FUND
3475 Hempstead Turnpike
Levittown, NY 11756
(516) 796–5660

VISION CARE BENEFIT CLAIM

Patients Name: _____ Soc. Sec. #: _____

Relationship to insured: _____

Patient's Address: _____

Member's Name: _____ Soc. Sec. #: _____

School: _____

I have incurred the following expenses and wish to be reimbursed by the Supplemental Benefits Fund.

Service	**Date of Service**	**Cost**
Eye Examination	_____ Mo. Day Yr.	$ _____
Eye Glasses	_____ Mo. Day Yr.	$ _____
Repair or Replacement Of eyeglass, frame	_____ Mo. Day Yr.	$ _____
Replacement of Lenses	_____ Mo. Day Yr.	$ _____
Purchase of Contact Lenses	_____ Mo. Day Yr.	$ _____

Name of Optometrist: _____

Address: _____

I am enclosing my **Itemized paid Receipt** for the above Service(s) with this claim form.

_____ _____
Member's Signature Date

This claim form (include any bills for services) should be mailed to the address on the top of this form within **90 days of the date you receive vision care services**.

Date Rec'd by LUT _____ Issued Check # _____

Amount Paid $ _____ Date Paid _____