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

VISION CARE CLAIM FORM

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 $200 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, must 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**

TO BE COMPLETED BY FFT BENEFIT FUND OFFICE ONLY

Approved by: _____ Amount Submitted: _____

Date Processed: _____ Amount Reimbursed: _____

Check Number: _____ Amount Not Covered: _____

6/2008