Yonkers Federation of Teachers Welfare Fund

35 East Grassy Sprain Road
Suite 502
Yonkers, New York 10710

STATEMENT OF CLAIM FOR OPTICAL BENEFIT

A BENEFIT OF UP TO $200 IS PROVIDED ONCE PER CALENDAR YEAR FOR EYE EXAMINATIONS, PRESCRIPTION LENSES AND/OR FRAMES FOR YOURSELF AND UP TO $125 FOR EACH ELIGIBLE DEPENDENT. YOU MUST SUBMIT WITH THIS CLAIM FORM THE ORIGINAL PAID RECEIPT WHICH INCLUDES THE PATIENTS NAME, THE DATE AND SERVICES RENDERED AND THE CHARGES. PAYMENT WILL BE MADE DIRECTLY TO YOU. IF SERVICES ARE PERFORMED BY A RELATIVE, THEN BENEFITS ARE LIMITED TO ONLY PAYMENTS MADE. PROOF ACCEPTABLE TO THE FUND MUST BE SUBMITTED. YOUR CLAIM MUST BE IN THE FUND OFFICE OR POSTMARKED NO LATER THAN MARCH 31ST FOLLOWING THE END OF THE CALENDAR YEAR IN WHICH THE EXPENSE WAS INCURRED. ALL ITEMS LISTED ON THE OPTICAL FORM WILL BE SUBJECT TO VERIFICATION.

The above constitutes a summary of the eligibility requirements and claims procedures. Members are to refer to the Benefit Booklet published by the Welfare Fund for the full official regulations.

MEMBER MUST COMPLETE THIS SECTION

Patient's Name	Relationship to Member ☐self ☐spouse ☐child ☐other		Patient's Birthday
Name of Member		Social Security Number	Date of Birth
Home Address	City	State Zip Code	Home Phone
Name of School or Building Assignment		Date of Employment in Yonkers System	

Is optical available from any other Yonkers Federation of Teachers Member? ☐ YES ☐ NO
Are optical benefits available from any other provider for this patient? ☐ YES ☐ NO
If you answer yes to either of the above questions, please complete the following information.

Dependent's Name_____ Social Security Number_____

Benefit Plan other than YFT and policy number _____

Are any of the vision charges in connection with a sickness or accident which is due in any way to your occupation? ☐ YES ☐ NO
Was any of the vision care treatment required because of accidental injury? ☐ YES ☐ NO

If your answer to either of the above is YES, attach a statement explaining the circumstances fully, including dates.

Service Performed: Check one or more boxes.
☐ Eye Examination ☐ Lenses ☐ Frames Amount Claimed $ _____

I certify that the forgoing information is true and correct. I understand I am financially responsible for any expense not covered by this benefit.

Date _____ Member's Signature _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR DECEIVE THE WELFARE FUND, FILES AN APPLICATION FOR COVERAGE OR A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

PLEASE MAIL FORM TO: YONKERS FEDERATION OF TEACHERS WELFARE FUND
35 EAST GRASSY SPRAIN ROAD, YONKERS, NY 10710

FOR ADMINISTRATOR ONLY

MEMBER/DEPENDENT	AMOUNT PAID _____	FOR YEAR _____