

# YORKTOWN CONGRESS OF TEACHERS WELFARE FUND

2729 Crompond Road  
Yorktown Heights, NY 10598  
914-962-7442



## OPTICAL BENEFIT

STATEMENT OF CLAIM FOR THE YEAR 20\_\_\_\_\_

You may claim up to limit per calendar year for the costs of "OPTICAL EXPENSES" for yourself or a member of your family, provided they meet the requirements as dependents. Claims for lenses, frames or contacts may be submitted directly to the Fund. You must submit a copy of the appropriate bill indicating the patients name, date(s) of service, type of service, and the charges, and an indication of the amount of deductible incurred in those charges. Payment will be made directly to you. Exams are reimbursable only every other year

**CLAIMS FOR EYE EXAMS UNDER THIS BENEFIT CATEGORY MUST BE SENT TO YOUR MEDICAL INSURANCE BEFORE SUBMISSION TO THE FUND.**

**NO PAYMENTS WILL BE MADE FOR ANY REASON 90 DAYS AFTER THE YEAR IN WHICH SUCH OPTICAL EXAM EXPENSES WERE INCURRED.**

### MEMBER MUST COMPLETE THIS SECTION

NAME OF MEMBER \_\_\_\_\_

BUILDING ASSIGNMENT \_\_\_\_\_

JOB CATEGORY \_\_\_\_\_

AMOUNT CLAIMED \_\_\_\_\_

I understand that I am responsible for any expense not covered by this benefit.

Date: \_\_\_\_\_ Member's Signature: \_\_\_\_\_

Retirees, please provide current address that you want benefit mailed to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### FOR TRUSTEES USE ONLY

DATE OF PAYMENT \_\_\_\_\_

CHECK# \_\_\_\_\_

AMOUNT PAID \_\_\_\_\_

CLAIMS MAY BE SENT VIA INTERSCHOOL MAIL TO YCT WELFARE FUND IN BUILDING B