Pressmen's-Publishers' Benefit Funds

OPTICAL EXPENSE CLAIM FORM

Maximum Benefit: $100.00 every calendar year for the active participant and each eligible dependent, for eye exams, contact lenses or prescription glasses.

Please enclose the original bill with this form. The bill must state the employee's name and address, patient's name, the service which was performed, date of services and amount of purchase. If glasses are purchased the bill must have the word "prescription" written on it, or enclose a copy of the prescription. No Photostat copies, charge receipts or cancelled checks can be considered for reimbursement.

Please print and complete the following:

1. Employee's name ______________________________ S.S Number__________
   Last First

2. Home Address______________________________
   St. Apt. City State Zip

3. Department where employed ______________ Work Phone __________

4. Name of Patient (if different then employee)______________________

   Relationship to employee______________________

5. Is the patient employed? _____Yes _____No Patient's S.S.# __________

   Name and Address of Patient's Employer:

   ____
   Employer's Name

   ____
   Address

6. Employee Signature______________________Date__________

D.O.S ______________________ Eligibility Date______________

PD.__________ BAL__________ CK#______________

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