New York State Correctional Officers and Police Benevolent Association, Inc. (NYSCOPBA)

Retiree Prescription Eyeglass and Contact Lens Reimbursement Program
Reimbursement Claim Form

Retiree Member Information (Please Print)

Retiree's Last Name: _____First:_____MI:____

Street Address: _____

City: _____State: _____Zip: _____

Home Phone # (_____) _____-_____Social Security # _____-_____-_____

The prescription eyeglass and contact lens reimbursement program allows eligible NYSCOPBA Retiree Chapter Members to purchase prescription eyeglasses or contact lenses from the provider of their choice and be reimbursed based on the paid receipt up to a $100 maximum per year. At year end, claims must be submitted for reimbursement by March 31 of the following year.

Name of prescription eyeglass or contact lens provider:

_____

Amount paid per receipt: _____

Reimbursement is for: ____ Prescription Eyeglasses ____Contact Lenses

Have you received a reimbursement already this year? ___No ___Yes

If yes, please indicate amount previously reimbursed $_____

Important Note: The Members name must be listed on the original paid receipt and submitted with the claim form. Reimbursement will not be made unless the original receipt is attached.

Please mail your completed claim forms to:

Norvest Financial Services
930 Albany-Shaker Road
Latham, New York 12110

Any questions regarding this program should be directed to the Norvest Customer Service Representatives toll free at 1-888-869-8252. Claim forms are available by calling Norvest or visiting their website at www.norvest.net.

I hereby certify that the information provided is true and accurate and the receipt attached is the original copy for the expenditure for which I request reimbursement.

Signature: _____ Date: _____