U.C.E. OF F.I.T. WELFARE FUND

FULL-TIME, PART-TIME & RETIREE'S - MEMBER SPOUSE & DEPENDENT OPTICAL VOUCHER

Fulltime_____ Part Time:_____ Retiree: _____

SEND COMPLETED FORMS TO:
THE SENECA GROUP
111 Smithtown Bypass Suite 207,
Hauppauge, NY 11788
or fax with a copy of the receipt to: **516-977-3333**

MEMBER PLEASE COMPLETE:

1. Member's Full Name _____ Soc. Sec. # XXX-XX-_____
2. Member's Address _____ City _____ State _____

   Zip Code _____ Tel. # _____

Dependent Children are covered up to age 26 if they are not covered by their own / spouses medical plan.

3. If claim is for a DEPENDENT, give name _____ Relation _____ D.O.B. _____
4. Present Place of Employment _____ Tel. # _____

A COPY OF AN ITEMIZED RECEIPT IS REQUIRED FOR DIRECT REIMBURSEMENT, OR YOU CAN

HAVE YOUR OPTOMETRIST, OPTICIAN OR OPHTHALMOLOGIST FILL IN / AUTHORIZE THE INFORMATION BELOW

☐ Examination ☐ Tint
☐ Single vision lenses ☐ Oversize
☐ TK Bifocal lenses ☐ Plastic
☐ FT 25 Bifocal lenses ☐ ☐ Frame
☐ Contact Lens ☐ Other (Specify)

Charged to Fund $ _____ **Charged to Member $** _____

DECLARATION: TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE AND CORRECT.

COUNTERSIGNATURE AT OPTICAL OFFICE: _____

Date _____ Signed _____ License No. _____

Name of Optical Center: _____

Address _____ Tel. No. _____

Check One: Ophthalmologist _____ Optician _____ Optometrist _____