



Local 1070 State Employees

DISTRICT COUNCIL 37 HEALTH & SECURITY PLAN
 125 BARCLAY STREET, NEW YORK, N.Y. 10007 (212) 815-1234

CLAIM FOR DIRECT OPTICAL REIMBURSEMENT

DC37 NYS Local 1070 active bargaining unit members, spouses/domestic partners and dependents will each be eligible to receive up to a maximum of \$300 optical reimbursement on annual basis.

The Optical Benefit provides three types of services once in a twelve-month period for eligible bargaining unit members and their dependents: eye examination, and/or frames, and/or lenses. THE TOTAL OPTICAL BENEFIT (ALL THREE TYPES OF SERVICES) MUST BE SUBMITTED AT THE SAME TIME BY EACH COVERED PERSON. (This rule applies to usage by an individual. It does not mean, for example, that all covered members in a family must use the benefit at one time.)

The Optical benefit is only available for one instance of service in each 12-month period. If only part of the Optical benefit is obtained and submitted for Direct Reimbursement, the part not utilized at the time of the first submission cannot be submitted within the same twelve months. This form must be use if you are seeking reimbursement.

| E M P L O Y E E | THIS SECTION IS FOR EMPLOYEE INFORMATION. PLEASE PRINT CLEARLY. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|------------------------|---|---------|-----------------|--|----|--------|--|----|----------------------|--|----|----------------|--|----|-----------------|--|----|--------------------|--|----|----------------|--|----|--|--|----|------------------------------------|--|----|-------------------------|--|----|-------|--|----|---|-----------------|--------------|---------|-------------|--|----|-------------------------|--|----|-------------------------|--|----|----------------------|--|----|---------------------|--|----|---------------|--|----|-------|--|
| | Member's Social Security No. or PID No. | Last Name | First Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Number and Street Address | Apt. No. | City & State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | (Area Code) Business Phone | (Area Code) Home Phone | (Area Code) Cell Phone | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Department | | Job Title | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | First Name | | Last Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SPOUSE/DOMESTIC PARTNER <input type="checkbox"/> CHILD | | Employee's Signature _____ Date _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | THIS SECTION IS FOR PROVIDERS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | COVERED SERVICES: Please complete the requested and applicable information: | | OTHER SERVICES: Please complete the requested and applicable information: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">TYPE OF SERVICE</th> <th style="width: 10%;">Please Check</th> <th style="width: 20%;">CHARGES</th> </tr> </thead> <tbody> <tr><td>Eye Examination</td><td></td><td>\$</td></tr> <tr><td>Frames</td><td></td><td>\$</td></tr> <tr><td>Single Vision Lenses</td><td></td><td>\$</td></tr> <tr><td>Bifocal Lenses</td><td></td><td>\$</td></tr> <tr><td>Trifocal Lenses</td><td></td><td>\$</td></tr> <tr><td>Progressive Lenses</td><td></td><td>\$</td></tr> <tr><td>Contact Lenses</td><td></td><td>\$</td></tr> <tr><td>Cataract Single Vision Lenses over +8.00</td><td></td><td>\$</td></tr> <tr><td>Cataract Bifocal Lenses over +8.00</td><td></td><td>\$</td></tr> <tr><td>Cataract Contact Lenses</td><td></td><td>\$</td></tr> <tr><td style="text-align: right;">Total</td><td></td><td>\$</td></tr> </tbody> </table> | TYPE OF SERVICE | Please Check | CHARGES | Eye Examination | | \$ | Frames | | \$ | Single Vision Lenses | | \$ | Bifocal Lenses | | \$ | Trifocal Lenses | | \$ | Progressive Lenses | | \$ | Contact Lenses | | \$ | Cataract Single Vision Lenses over +8.00 | | \$ | Cataract Bifocal Lenses over +8.00 | | \$ | Cataract Contact Lenses | | \$ | Total | | \$ | <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">TYPE OF SERVICE</th> <th style="width: 10%;">Please Check</th> <th style="width: 20%;">CHARGES</th> </tr> </thead> <tbody> <tr><td>Solid Tints</td><td></td><td>\$</td></tr> <tr><td>High Luster Edge Polish</td><td></td><td>\$</td></tr> <tr><td>Anti-Reflective Coating</td><td></td><td>\$</td></tr> <tr><td>Polycarbonate Lenses</td><td></td><td>\$</td></tr> <tr><td>Photochromic Lenses</td><td></td><td>\$</td></tr> <tr><td>UV Protection</td><td></td><td>\$</td></tr> <tr><td style="text-align: right;">Total</td><td></td><td>\$</td></tr> </tbody> </table> | TYPE OF SERVICE | Please Check | CHARGES | Solid Tints | | \$ | High Luster Edge Polish | | \$ | Anti-Reflective Coating | | \$ | Polycarbonate Lenses | | \$ | Photochromic Lenses | | \$ | UV Protection | | \$ | Total | |
| TYPE OF SERVICE | Please Check | CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Eye Examination | | \$ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Frames | | \$ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Single Vision Lenses | | \$ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bifocal Lenses | | \$ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Trifocal Lenses | | \$ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Progressive Lenses | | \$ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Contact Lenses | | \$ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cataract Single Vision Lenses over +8.00 | | \$ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cataract Bifocal Lenses over +8.00 | | \$ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cataract Contact Lenses | | \$ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total | | \$ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TYPE OF SERVICE | Please Check | CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Solid Tints | | \$ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| High Luster Edge Polish | | \$ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Anti-Reflective Coating | | \$ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Polycarbonate Lenses | | \$ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Photochromic Lenses | | \$ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| UV Protection | | \$ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total | | \$ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER Name: _____ Address: _____ Telephone No. _____ Date of Services: _____ | DISPENSER Name: _____ Address: _____ Telephone No. _____ Date of Services: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| FOR OFFICE USE ONLY • DO NOT WRITE HERE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Claim No. | Amount | Claim Examiner | Date | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |