RETURN BY MAIL OR FAX TO:
SCCEA, Welfare Fund
1363-24 Veterans Memorial Hwy.
Hauppauge, New York 11788
(631) 231-3983 FAX: 631-231-3986

Suffolk County Court Employees
Association Welfare Fund

OPTICAL BENEFIT FORM - 2020

PATIENT INFORMATION (REQUIRED ON CLAIMS FOR SPOUSES AND DEPENDANTS)

Patient Name	Birthdate	Relationship to Member	School (if applicable)	Full Time Student _____ Yes _____ No

MEMBER/EMPLOYEE INFORMATION:

Member Name		Birthdate	Social Security # LAST 4 DIGITS XXX – XXX - ____ ____ ____ ____
Street Address City	State Zip		Plan Status ____ SINGLE ____ FAMILY
Phone (Day Time)			

****POSITION/JOB TITLE:**_____________________________________****LOCATION/WORK STATION:**____________________________

SPOUSE INFORMATION:

Spouse Name	Birthdate	Social Security # LAST 4 DIGITS XXX – XXX - ____ ____ ____ ____
Name, Address, and Telephone # of Spouse's Employer		Name Of Benefit Plan
ARE ANY OTHER OPTICAL BENEFITS AVAIABLE FOR THIS PATIENT?____ YES ____ NO		

OPTICAL BENEFIT FORM FOR NON-PARTICIPATING PROVIDERS - PLEASE ATTACH PAID RECEIPTS FOR FOR CLAIM.

- **The copy of receipt showing payment of Optical Services obtained from any licensed Optometrist, Ophthalmologist or Optician. Reimbursement for all claims shall be based on a ONE-TIME PAYMENT per plan participant**

This benefit must be coordinated with any other plan under which provides optical coverage. Where both spouses are eligible employees your dependent children will be covered to a maximum of the normal, reasonable and customary charges or the actual charges, whichever is less, available through the combined coverage of both spouses. The claims of both spouses **MUST** be submitted together.

PROVIDER INFORMATION (DISPENSER OF FRAMES AND/OR LENSES)**:**

Provider Name	License #	Taxpayer ID#
Street Address City State Zip		Exam Fee:
Telephone# Date		

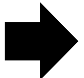
SERVICE	FEE ($)	DATE	FOR OFFICE USE
FRAMES			
LENSES SingleVision			
Bifocal			
Trifocal			
Lenticular			
Contact Lenses			

You may check on eligibility for this benefit 24 hours a day, 7 days a week by phone: (516) 396-5561 (800) 537-1238 x5561

Or online: www.asonet.com

AUTHORIZATION TO RELEASE INFORMATION: **Authorization must be signed or payment will not be made.**

I hereby authorize any insurance company, prepayment organization, hospital, physician, or The Board of Trustees of the Suffolk County Court Employees Association, Welfare Fund or its designated agent to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy of this authorization, when duly executed, shall serve in the same capacity as the original. I certify that the information submitted by me in support of this claim is true and correct.



Reimbursement Amount Requested TO MEMBER $ _________

Note: Total allowable 2020 reimbursement - $150 per calendar year.

Member Signature: ____ **Date:** ______________________________

***PAYMENT OF BENEFITS TO PROVIDER:** *I hereby authorize payment for the benefits* **(OTHERWISE PAYABLE TO ME)** *directly to the above-named physician. I understand I am financially responsible for charges not covered by this authorization*

Member Signature: ____ **Date:**______________________________

ALL OPTICAL CLAIMS MUST BE SUBMITTED NO LATER THAN DECEMBER 31ST OF THE CALENDAR YEAR IN WHICH THE SERVICE WAS PERFORMED – NO EXCEPTIONS

Rev. 8/20

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