

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**

PO Box 1043

Matthews, NC 28106

or fax with a copy of the receipt to: **866-223-6521**

Customer Service 866-487-4157

Email: Services@thesenecagroup.com

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

- | | |
|--|--|
| <input type="checkbox"/> Examination | <input type="checkbox"/> Tint |
| <input type="checkbox"/> Single vision lenses | <input type="checkbox"/> Oversize |
| <input type="checkbox"/> TK Bifocal lenses | <input type="checkbox"/> Plastic |
| <input type="checkbox"/> FT 25 Bifocal lenses <input type="checkbox"/> Frame | |
| <input type="checkbox"/> Contact Lens | <input type="checkbox"/> 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 _____