EAST WILLISTON TEACHERS ASSOCIATION
BENEFIT FUND
253 West 35th Street, 12th Floor
New York, NY 10001

SUPPLEMENTAL OPTICAL BENEFIT FORM

FOR RETIREES WHO HAVE DENTAL COVERAGE AT TIER 2 ($2,000) OR TIER 3 ($3,000) LEVEL

RETIREE AND ELIGIBLE DEPENDENTS

Patient's Name: _____

Relationship to member: _____

Member's Full Name: _____

Social Security #: _____

Member's Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____

Date: _____

Member's Signature: _____

The Supplemental Optical Benefit provides reimbursement for each covered dependent up to $125.00 every two years.

This benefit is available to you whether or not you have vision care coverage under the Excess Major Medical Plan. This benefit shall be considered secondary to any coverage you do have. Please attach copies of receipts and all related statements of vision care payments you have received to this form. Mail completed materials to the above address.