DISTRICT COUNCIL #4
585 AERO DRIVE
CHEEKTOWAGA, NY 14225

OPTICAL FORM

FOR OPTICAL REIMBURSEMENT

NAME: ____

ADDRESS: ____

____

Last 4 of SS# ____-____-____-____

PLEASE CHECK BELOW

PDC #4 TWO BENEFITS EACH PER YEAR FOR QUALIFYING MEMBER

UP TO $50.00 FOR LENSES $ ______________

UP TO $30.00 FOR EXAM $ ______________

Total Reimbursement $ ______________

I hereby request the remaining balance of optical receipts submitted, to be taken from my Medical reimbursement account. ____YES

SIGNATURE ____________________ DATE ______________