NATIONAL ASSOCIATION OF LETTER CARRIERS
BRANCH 1477, NALC

EYE GLASS PLAN
5369 Park Boulevard North
Pinellas Park, FL 33781-3421

APPLICATION FOR REIMBURSEMENT

Name of Member____________________ **Social Security No.**____________

Address________________ **City**____________ **State** ____ **Zip**______

Phone____________ **Member** ______ **Member's Dependent**____

Patient #1______________ **Date of Birth**________ **Date of Examination**________

Patient #2______________ **Date of Birth**________ **Date of Examination**________

Patient #3______________ **Date of Birth**________ **Date of Examination**________

Fee #1________ **Fee #2**________ **Fee #3**________

Physician **Name**________________________

Address________________________

City/State/Zip________________________

Phone Number____________

Examination Fee____________

I hereby authorize the above named doctor to release information pertaining to the examination.

Signature of member or authorized agent____________________________

Reimbursement will be made pursuant to the Branch Bylaws as amended.

NO CLAIM FOR PAYMENT WILL BE CONSIDERED WITHOUT THE INFORMATION ABOVE.

RETURN BOTH COPIES WITH EXAMINATION BILLS ATTACHED

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For Official Use Only:

Date of Approval____________ **Approved by**________________

Paid by Check No.__________ **Date**__________ **Amount**____________