NATIONAL ASSOCIATION OF LETTER CARRIERS
BRANCH 1477
EYE GLASS PLAN

5369 Park Boulevard N.
Pinellas Park, Fl. 33781-3421

APPLICATION FOR REIMBURSEMENT

Name of Member:____

Address:____

City:____State:____Zip:_____

Phone:______________________Member:___Member's Dependents:_____

(please check one)

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_________________Examination Fee_____________

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

Member Signature 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.

PLEASE ATTACH A COPY OF THE EXAMINATION BILL

SHOWING PAYMENT MADE

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For Official Use Only :

Date of Approval____________Approved by:__________Check #________Amount__________