Westchester C.O.B.A Welfare Fund

Lasik Surgery Reimbursement Claim Form

Employee Name: ______________________________ Active: ☐ Retired: ☐

Address: ____

Phone #: ____________________________________

Payment is limited to $1250.00 per eye per member in a five year period. Using this benefit may suspend your vision benefit for five years. This benefit is only for the **Active/Retired Correction Officer**.

Be sure your bills and receipts are copied and attached. **Do not send originals.** This completed form can be mailed to:

Westchester C.O.B.A Welfare Fund

PO BOX 231

Thornwood, N.Y. 10594

Right Eye Date: _______________

Left Eye Date: _______________

Dr. Name: ______________________________________

Address: ____

Phone #: ____

I certify that the above information is accurate and that the charges indicated were incurred by me. I have not received payment for the amount of this claim from any other insurer, benefit fund, IRC 125 plan or by any other means.

_________________________ Members Signature

_______________ Date

Rev: 12/3/19