WARWICK VALLEY TEACHERS
Vision Care Reimbursement

Employee Name: ____

Address: ____

City: _________________________ **State:** _______________ **Zip:** ____________

CLAIMANT: **SELF** ______ **SPOUSE** ______ **DEPENDENT** _______

NAME: ____

Provider Statement

Name: ____

TYPE OF SERVICE		DATE	CHARGE
EXAM		_________	$__________
LENS	SINGLE VISION	_________	$__________
	BI-FOCAL	_________	$__________
	TRI-FOCAL	_________	$__________
	PROGRESSIVE	_________	$__________
	CONTACT LENS	_________	$__________
FRAMES		_________	$__________

****

I Hereby Certify That the Above Statements Are Correct And Services Are Not Covered By Other Plans.

Claimant's Signature: __________________________________ **Date:** _____

RETURN FORM TO:
THE PREFERRED GROUP
P.O. BOX 15136
ALBANY, NY 12212-5136
PHONE: (518) 641-0321 * (800) 573-7474
FAX: (518) 641-0325