RETURN TO:
SCCEA Welfare Fund
1363-24 Veterans Memorial Hwy.
Hauppauge, New York 11788
(631) 231-3983 FAX: 631-231-3986
email: sccea@aol.com

Suffolk County Court Employees Association Welfare Fund

OPTICAL BENEFIT FORM - 2026

PATIENT INFORMATION (REQUIRED ON CLAIMS FOR SPOUSES AND DEPENDANTS)

Patient Name	Birthdate	Relationship to Member	School (if applicable)	Full Time Student ____ Yes ____ No

MEMBER/EMPLOYEE INFORMATION:

Member Name				Birthdate	Social Security # LAST 4 DIGITS XXX – XXX - ___ ___ ___ ___
Street Address	City	State	Zip		Plan Status ☐ SINGLE ☐ FAMILY
Phone (Day Time)					

****POSITION/JOB TITLE:**_____ ****LOCATION/WORK STATION:**_____

SPOUSE INFORMATION:

Spouse Name	Birthdate	Social Security # LAST 4 DIGITS XXX – XXX - ___ ___ ___ ___
Name, Address, and Telephone # of Spouse's Employer		Name Of Benefit Plan
ARE ANY OTHER OPTICAL BENEFITS AVAILABLE FOR THIS PATIENT? ☐ **YES** ☐ **NO**		

OPTICAL BENEFIT FORM FOR NON-PARTICIPATING PROVIDERS - PLEASE ATTACH PAID RECEIPTS FOR CLAIM.

- **The copy of receipt showing payment of Optical Services obtained from any licensed Optometrist, Ophthalmologist or Optician. Reimbursement for all claims shall be based on a ONE-TIME PAYMENT per plan participant**

This benefit must be coordinated with any other plan under which provides optical coverage. Where both spouses are eligible employees, your dependent children will be covered to a maximum of the normal, reasonable and customary charges or the actual charges, whichever is less, available through the combined coverage of both spouses. The claims of both spouses **MUST** be submitted together.

PROVIDER INFORMATION (DISPENSER OF FRAMES AND/OR LENSES**):**

Provider Name	License #	Taxpayer ID#
Street Address City State Zip		Exam Fee:
Telephone# Date		

SERVICE	FEE ($)	DATE	FOR OFFICE USE
FRAMES			
LENSES SingleVision			
Bifocal			
Trifocal			
Lenticular			
Contact Lenses			

You may check on eligibility for this benefit 24 hours a day, 7 days a week by phone: (516) 396-5561 (800) 537-1238 x5561

Or online: www.asonet.com

AUTHORIZATION TO RELEASE INFORMATION: **Authorization must be signed or payment will not be made.**

I hereby authorize any insurance company, prepayment organization, hospital, physician, or The Board of Trustees of the Suffolk County Court Employees Association, Welfare Fund or its designated agent to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy of this authorization, when duly executed, shall serve in the same capacity as the original. I certify that the information submitted by me in support of this claim is true and correct.

Reimbursement Amount Requested TO MEMBER $ _____ **Note: Total allowable 2026 reimbursement - $150 per calendar year.** ____

Member Signature: _____ **Date:** _____

******OR******

I hereby authorize payment for the benefits **TO PROVIDER** *directly to the above-named physician. I understand I am financially responsible for charges not covered by this authorization.*

Member Signature: _____ **Date:**_____

OPTICAL CLAIMS MUST BE RECEIVED BY THE UNION OFFICE NO LATER THAN DECEMBER 31st 2026 WHICH IS THE LAST BUSINESS DAY OF THE CALENDAR YEAR TO BE PROCESSED – NO EXCEPTIONS

Rev. 12/25

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