SOMERS FACULTY ASSOCIATION BENEFIT TRUST FUND
VISION CLAIM FORM

1. EMPLOYEE'S NAME		2. ALTERNATE ID # OR SSN	
3. EMPLOYEE'S MAILING ADDRESS (CITY)		(STATE OR PROVINCE)	(ZIP CODE)
4. PATIENT NAME (IF A DEPENDENT)	5. RELATOINSHIP TO EMPLOYEE	6. BIRTH DATE	7. TELEPHONE NUMBER
8. DOES PATIENT HAVE OTHER HEALTH COVERAGE (IF YES, PLEASE IDENTIFY) YES__ NO_			

Maximum Benefit: $500.00

- Services must be incurred between July 1, 2024 and June 30, 2025.
- All claims for the fiscal year ending on June 30, 2025 must be received by The Preferred Group by September 30, 2025.

Name of Member Or Dependent	**Date of Service**	**Doctor Statement & Receipt Attached**	**Amount of Vision Benefits**
____________________	__________	___________	$____________
____________________	__________	___________	$____________

- Vision expenses must be incurred by you, your spouse, and/or eligible dependent children and not reimbursed by any other dental or vision plan.
- Please include a copy of the Doctor's statement and/or receipt.
- Providers may submit an HCFA form if submitting this claim on behalf of a member.
- Services must be incurred between July 1, 2024 and June 30, 2025.
  All claims must be received at The Preferred Group by September 30, 2025.
- Claims will be processed and mailed in 2-3 weeks from receipt of submission.
  In the event you do not receive a check for a claim within this time frame please call (518) 641-0321

______________________________ Signature

______________________________ Date

Claims can be submitted one of two ways:

Claim forms can be mailed to this address:	**Claim Forms can be scanned and emailed to:**
SOMERS FACULTY ASSOCIATION TRUST FUND **c/o The Preferred Group** **PO Box 15136** **Albany, NY 12212**	**claims@tpgplans.com** ➢ **When emailing "Somers Claims" must be included in the subject line.**