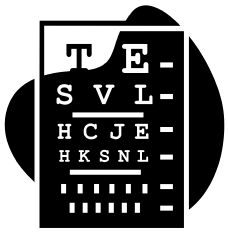
Arlington Teachers' Association Welfare Trust Benefit Fund
→Vision Care Claim Form←



ARLINGTON TEACHERS' ASSOCIATION
C/O PREFERRED GROUP PLANS, INC.
PO BOX 15136
ALBANY, NY 12212-5136
(800) 573 - 7474
(518) 641 – 0321

RON HIGGINS, CHAIRPERSON
ED HOTALING, JR., MEMBERSHIP
KRISTEN OUIMET, TRUSTEE
SIOUXZANNE HARRIS, TRUSTEE
EUGENE FRANK, TRUSTEE
BOB MAIER, TRUSTEE

ATA WELFARE TRUST BENEFIT FUND
→VISION CARE CLAIM FORM←

MEMBER'S NAME _____
LAST FIRST MIDDLE

MEMBER'S HOME ADDRESS _____

_____

_____

_____

MEMBER'S PHONE NUMBER _____

MEMBER'S SOCIAL SECURITY NUMBER(OPTIONAL) _____

AMOUNT OF CLAIM SUBMITTED ($300.00 MAXIMUM) $ _____

EMPLOYEE SIGNATURE _____

PLEASE MAKE CERTAIN YOU ATTACH A COPY OF YOUR RECEIPT OR RECEIPTS INDICATING YOUR VISION CARE RELATED EXPENSES. THE MAXIMUM BENEFIT FOR VISION CARE IS $300. FOR THE FISCAL YEAR BEGINNING OCTOBER 1ST AND ENDING SEPTEMBER 30th OF ANY GIVEN YEAR. CLAIMS MUST BE FILED NO LATER THAN THREE MONTHS FOLLOWING THE END OF THE FISCAL PERIOD.

PLEASE RETURN THIS COMPLETED FORM (ALONG WITH ATTACHED RECEIPTS) TO: ARLINGTON TEACHERS' ASSOCIATION, C/O PREFERRED GROUP PLANS, INC., PO BOX 15136, ALBANY, NY 12212-5136.

(Office Use Only) _____