

GOOD UNTIL _____

No. _____

**OPTICAL CERTIFICATE
RETIRED FIRE OFFICERS FAMILY PROTECTION PLAN**
Uniformed **FIRE OFFICERS** Association - **Local 854** IAFF AFL-CIO
225 BROADWAY • SUITE 411 • NEW YORK, N.Y. 10007 • (212) 376-8400

.....
SIGNATURE OF MEMBER

.....
SOCIAL SECURITY NO.

.....
SIGNATURE OF DEPENDENT - IF APPLICABLE

.....
IF FULL TIME STUDENT OVER 19 YRS. GIVE NAME AND ADDRESS OF SCHOOL

			Dependent's Relationship	
MEMBER'S NAME			SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/>	
ADDRESS			Birth Date of Child	
CITY	STATE	ZIP		

This certificate is not transferable. It will not be honored if countersigned prior to eye examination.

.....
COUNTERSIGNATURE *at Optical Office Only*

INSTRUCTIONS FOR USE • Please read before filling out reverse side.

- All covered Retirees and eligible dependents are entitled to obtain one (1) eye examination and one (1) pair of eyeglass every two (2) years. **Sun Glasses are not included.**
- Member** shall sign the attached certificate on line indicated near top and **add his Social Security Number.**
- If certificate is for a **dependent**, he or she **must sign in addition** to the **Member** in the space provided.
IF FULL TIME STUDENT OVER 19 YEARS GIVE NAME AND ADDRESS OF SCHOOL
- Mail certificate to Plan office where eligibility will be verified and the validated certificate will be returned to you. **It cannot be used without the official validation.**
- Approved certificate is good up to the date stamped on the upper left corner of certificate. Use it at any of the optical plan locations - or your private optometrist or optician.
- Counter signature must be made at Optical Office** by the person to whom the certificate was issued.
- If private optometrist or optician is used**, return this card with lower portion completed **together with a PAID ITEMIZED bill.** You will be reimbursed directly for expenses in accordance with approved schedule of fees.

TO BE COMPLETED BY OPTICAL PLAN OFFICE - PRIVATE OPTOMETRIST OR OPTICIAN

- | | |
|--|--|
| <input type="checkbox"/> FRAME - within allowance | <input type="checkbox"/> SV LENSES |
| <input type="checkbox"/> EXAMINATION | <input type="checkbox"/> TK LENSES - Bifocal |
| <input type="checkbox"/> OTHER OPTICAL SERVICE (Specify) _____ | <input type="checkbox"/> CHARGE TO PLAN \$ _____ |
| _____ | <input type="checkbox"/> CHARGE TO MEMBER \$ _____ |