IAFF Local 587 Health Insurance Trust Fund
Advanced Eye Care
Reimbursement Claim Form

(**Please submit separate forms for each claim**)

Subscriber/Member Information ***(Please print clearly)***

Subscriber Name	Subscriber ID Number	Subscriber Date of Birth	
Mailing Address	City	State	Zip
Phone Number	Email Address		

Patient Information

Name	Date of Birth	Purchase Date	Purchase Amount

- **Beginning in 2024**, reimbursements are available for **FDA approved procedures improving your eyesight** up to a maximum lifetime benefit of $5,000.00 per eligible member of the Plan.
- Reimbursements will be paid directly to the Subscriber/Member. The amount reimbursed will be the lesser total between the amount paid for the procedure or the $5,000.00 lifetime maximum benefit.
- Reimbursement requests must be turned in prior to March 31st, of the following year after the procedure.
- All reimbursements are subject to approval by the Trust.
- Reimbursement shall be limited to reasonable and customary costs.
- Failure to provide the proper documentation, including a completed reimbursement form and receipts showing the costs incurred for the FDA approved procedure shall be reason for the reimbursement request to be rejected.

Mail, email, or fax this completed form with a copy of the itemized invoice or receipt imprinted with the provider's name and address to the contact information below. Please retain the original for your records.

IAFF Local 587 Health Insurance Trust
2980 NW South River Drive
Miami, Fl. 33125

Email: benefits@healthtrustmaff.org
Fax: 305-633-3935

Questions?
Please call our office at 305-425-1938

Any person who knowingly and with intent to injure, defraud, or deceive by filing a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature ______________________ Date ______________