IAFF Local 587 Health Insurance Trust Fund
Vision Reimbursement Claim Form

(**Please submit separate forms for each dependent's claim**)

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

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

Patient Information

Dependent's Name	Date of Birth	Purchase Date	Purchase Amount

Vision Care Benefits – Eligibility for Reimbursement

Reimbursement is available for:

1. IAFF Local 587 Health Insurance Trust's subscribed dependents 19 years of age and under. (Please submit separate forms for each dependent's claim.)
2. Costs over $150.00 for up to a one-year supply of prescribed medically necessary contact lenses for the subscribed dependent purchased between January 1, 2020 – December 31st, 2020 at an In-Network Provider.

- Reimbursement requests must be turned in prior to March 31st, 2021.
- 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 contacts 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 _____