# IAFF Local 587 Health Insurance Trust Fund
# Lasik Reimbursement Claim Form

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

| Name | Date of Birth | Purchase Date | Purchase Amount |
|---|---|---|---|
| | | | |

- Reimbursements are available for **Lasik Procedures** up to a maximum allowance of $1,000 per eye completed during the calendar year beginning on January 1st and ending on December 31st.
- Reimbursements will be paid directly to the Member.
- 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 Lasik 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 ______________