SOMERS FACULTY ASSOCIATION BENEFIT TRUST FUND
VISION CLAIM FORM

1. EMPLOYEE'S NAME		2. ALTERNATE ID # OR SSN	
3. EMPLOYEE'S MAILING ADDRESS (CITY) (STATE OR PROVINCE) (ZIP CODE)			
4. PATIENT NAME (IF A DEPENDENT)	5. RELATOINSHIP TO EMPLOYEE	6. BIRTH DATE	7. TELEPHONE NUMBER
8. DOES PATIENT HAVE OTHER HEALTH COVERAGE (IF YES, PLEASE IDENTIFY) YES☐ NO☐			

Maximum Benefit: $500.00

- Services must be incurred between July 1, 2023 and June 30, 2024.
- All claims for the fiscal year ending on June 30, 2024 must be received by Zenith American Solutions by September 30, 2024.

Name of Member Or Dependent	Date of Service	Doctor Statement & Receipt Attached	Amount of Vision Benefits
_____	_____	_____	$_____
_____	_____	_____	$_____

- Vision expenses must be incurred by you, your spouse, and/or eligible dependent children and not reimbursed by any other dental or vision plan.
- Please include a copy of the Doctor's statement and/or receipt.
- Providers may submit an HCFA form if submitting this claim on behalf of a member.
- Services must be incurred between July 1, 2023 and June 30, 2024.
  All claims must be received at The Preferred Group by September 30, 2024.
- Claims will be processed and mailed in 2-3 weeks from receipt of submission.
  In the event you do not receive a check for a claim within this time frame please call (518) 641-0321

_____ _____

Signature **Date**

Claims can be submitted one of two ways:

Claim forms can be mailed to this address:	Claim Forms can be scanned and emailed to:
SOMERS FACULTY ASSOCIATION TRUST FUND **c/o The Preferred Group** **PO Box 15136** **Albany, NY 12212**	**claims@tpgplans.com** ➢ **When emailing "Somers Claims" must be included in the subject line.**