Vision Care Claim Form

Please attach this form to your bills for Eye Exams, Glasses or Contact Lenses*

Name of Employee: _____

Location/Department: _____

Job Title: _____

Employee's Home Address: _____

Employee's Date of Hire: _____

_____

Name of Patient: _____

_____

Relationship to Employee: _____

Employee's Signature: _____

Date: _____

*Bills must include the date and type of service and must be marked Paid-In-Full.

Eligible once every 12 Months from your last reimbursement.
Up to $50 for any exam.
Up to $150 for Glasses/Contacts

In order for dependent to be eligible for the reimbursement benefit, he/she must be covered under the employee's medical coverage.

Submit or Mail To:
League Education & Treatment Center
Human Resources
483 Clermont Avenue, 3rd FL
Brooklyn, NY 11238