

**NEW YORK STATE SUPREME COURT OFFICERS  
SECURITY BENEFIT FUND  
VISION CARE CLAIM FORM**

**RETURN COMPLETED FORM TO:**  
MALONEY ASSOCIATES, INC.  
211 BROADWAY  
LYNBROOK, NY 11563

**MEMBER'S STATEMENT (PRINT OR TYPE)**

MEMBER'S NAME	AGE	DEPENDENT'S NAME (If claim is on dependent)
ADDRESS		
RELATIONSHIP		
SOC. SEC. NO. <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/>	SEX	
WAS THE EXAMINATION REQUIRED BY: A. AN EMPLOYER AS A CONDITION OF EMPLOYMENT? B. BY A GOVERNMENT BODY	DATE OF BIRTH YES	MO. DAY YR. NO
ARE ANY OF VISION CARE CHARGES IN CONNECTION WITH A SICKNESS OR ACCIDENT WHICH IS DUE IN ANY WAY TO YOUR OCCUPATION? If "yes", furnish complete details. (attach separate statement in explanation)	<input type="checkbox"/>	<input type="checkbox"/>
I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT		
DATE _____	MEMBER'S SIGNATURE _____	

**DOCTOR'S STATEMENT (OPTOMETRIST OR PHYSICIAN)**

PATIENT'S NAME	AGE
EXAMINATION AND MATERIAL RECORD – LIST BELOW THE VISUAL EXAMINATION MADE AND MATERIALS ORDERED BY YOU.	
EXAMINATION: NATURE AND TYPE OF EXAMINATION (Describe fully)	
_____	
CHARGE FOR THIS EXAMINATION _____	DATE (S) PERFORMED _____
<b>MATERIALS:</b>	DATE (S) CHARGE (S)
FRAMES	
LENSES	
SINGLE VISION	OD OS _____
BI-FOCAL	<input type="checkbox"/> <input type="checkbox"/> _____
TRI-FOCAL	<input type="checkbox"/> <input type="checkbox"/> _____
LENTICULAR	<input type="checkbox"/> <input type="checkbox"/> _____
IF ANY OF THE MATERIALS WERE REPLACEMENT, FULLY EXPLAIN REASONS FOR REPLACEMENT	

IN ORDER TO PROPERLY EVALUATE THE EXPENSES DESCRIBED ABOVE, PLEASE ANSWER THE FOLLOWING QUESTIONS.

WERE THE SERVICES AND/OR MATERIALS IN CONNECTION WITH:	YES	NO
A. SPECIAL PPROCEDURES SUCH AS ORTHOPTICS AND VISUAL TRAINING?	<input type="checkbox"/>	<input type="checkbox"/>
B. MEDICAL OR SURGICAL TREATMENT? (IF YES DESCRIBE FULLY)	<input type="checkbox"/>	<input type="checkbox"/>
C. SICKNESS OR ACCIDENT ARISING OUT OF THE PATIENT'S EMPLOYMENT?	<input type="checkbox"/>	<input type="checkbox"/>
D. FITTING OF EITHER PLAIN SUNGLASSES OR PRESCRIPTION SUNGLASSES?	<input type="checkbox"/>	<input type="checkbox"/>
IF CONTACT LENSES WERE USED:		
A. COULD THE VISUAL ACUITY OF THE BETTER EYE BEEN CORRECTED TO 20/70 BY THE USE OF CONVENTIONAL TYPE LENS?	<input type="checkbox"/>	<input type="checkbox"/>
B. IF "NO" WAS IT CORRECTED TO BETTER THAN 20/70 BY THE USE OF CONTACT LENSES?	<input type="checkbox"/>	<input type="checkbox"/>

DOCTOR'S NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

(Please Print) (Degree) No. Street

DOCTORS SIGNATURE \_\_\_\_\_ City State

DATE \_\_\_\_\_ SOC. SEC. NO. \_\_\_\_\_ TELEPHONE \_\_\_\_\_

ASSIGNMENT OF INSURANCE BENEFITS (To be completed if payment is to be made optometrist or physician)

**I HEREBY AUTHORIZE PAYMENT OF THE BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE PROVISIONS OF THIS POLICY.**

TO DR. \_\_\_\_\_ SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

Please Print Member's Signature