BTF-SBF OPTICAL FORM

(PLEASE PRINT)

***IMPORTANT — A PAID RECEIPT MUST ACCOMPANY THIS FORM**

RETURN COMPLETED FORM **WITH RECEIPTS** TO:
BTF-SBF OPTICAL
271 PORTER AVENUE
BUFFALO, NEW YORK 14201

SECTION 1 — COMPLETED BY MEMBER AND SIGNATURE AT BOTTOM

1. Members Name FIRST MIDDLE LAST

2. Members Social Security No.

3. Members Mailing Address STREET | CITY | STATE | ZIP CODE | PAYROLL SCHOOL

4. Patient's Name | RELATIONSHIP TO MEMBER: Self | Spouse | Child | Other | SEX: M | F | PATIENT'S BIRTHDAY: Mo. | Day | Year

ELIGIBLE DEPENDENTS ARE COVERED UNTIL AGE 23.

SECTION 2 — COMPLETED BY EXAMINER

5. Patient's Name

6. Date of Exam Mo. | Day | Yr.

7. Charge for Exam

8. Type of Exam

9. ______________________
Signature of Examiner

If Doctor Please Check ☐

PREVIOUSLY USED BTF/SBF OPTICAL PLAN? ☐ YES ☐ NO

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SECTION 3 — COMPLETED BY DISPENSER

10. Lenses Dispensed

	Charge for 1st Pair	Charge for 2nd Pair
☐ Single Vision	________	________
☐ Flat-Top Bifocals	________	________
☐ Trifocals ☐ Plastic ☐ Glass	________	________
☐ Invisible Type ________	________	________
☐ Executive Bifocal	________	________
☐ Executive Trifocal	________	________
☐ Hi-Lite / Hi-Index Single Vision (circle one)	________	________
☐ 1 Pair Contacts	________	________
☐ Left Contact Only	________	________
☐ Right Contact Only	________	________
☐ UV 400	________	________
☐ Anti-reflective coating	________	________
☐ Other ________ (explain)		

11. Date Lenses Ordered ________

12. Charge For Frames

1st Pair ________

2nd Pair ________

Date Frames Ordered ________

***RECEIPTS MUST CORRESPOND WITH SUBMITTED SERVICES**

CALL 881-5462 TO CHECK YOUR ELIGIBILITY

13. ______________________
Signature of Dispenser

14. Name and Address of Firm

Under penalty of loss of all supplemental benefits, the above information is accurate to the best of my knowledge.

Signature of Member ______________________