VALLEY STREAM VOLUNTEER & EXEMPT FIREFIGHTER BENEVOLENT ASSOCIATION EYEGLASS & DENTAL ASSITANCE REQUEST FORM

Member is entitled to request assistance up to $500 in Eyeglass copayment/expense reimbursement, and up to $500 Dental copayment/expense reimbursement per calendar year. Services must be provided by a licensed professional who practice in eyecare or dental treatment.

INSTRUCTIONS:

1. Member must complete and send assistance request form.
2. Member must submit a paid receipt or explanation of benefits detailing date of services and member's cost.
3. All request for assistance must be received or postmarked no later than January 31 of the following year
4. Reimbursement checks will be mailed the month of March for all claims during the previous year.
5. Mail to: Valley Stream Vol & Expt Firefighters Benevolent Assoc
   PO Box 124 Attn: Members Assistance
   Valley Stream, NY 11582
   or Submitted to your Company or Exempt Trustee
   NO EMAIL or PICTURE PHOTO WILL BE ACCEPED

MEMBERS NAME		EMAIL ADDRESS	
ADDRESS		PHONE#	

Date of Treatment	Provider Name & License #	Address	Phone #	Dental or Eyewear	Members Cost

Members Signature & Date: _____

For office Only Use

Approved Amount	
Date & Check #	
Total	
Reviewing Trustee	

Jmf2024