RETIREE OPTICAL REIMBURSEMENT CLAIM FORM

Benefit Period 12/01/15 thru 12/31/2016

RETIREE NAME (PLEASE PRINT):				
RETIREE HOME ADDRESS, City, State, Zip Code:				
RETIREE DAYTIME PHONE, or Cell Phone Number:				LAST FOUR DIGITS OF RETIREE SS#: XXX-XX-
PERSON RECEIVING SERVICES: (If not RETIREE)				
RELATIONSHIP TO RETIREE: (Check ONE)	☐ Self	☐ Spouse	☐ Dependent	BIRTHDATE of person receiving services:
CUSTODIAL PARENT NAME: (IF APPLICABLE)				
CUSTODIAL PARENT SOCIAL SECURITY NUMBER: (IF APPLICABLE)				
CUSTODIAL PARENT HOME PHONE NUMBER: (IF APPLICABLE)				
TOTAL AMOUNT OF RECEIPT:	DATE (S) OF SERVICE:			

EMPLOYEE SIGNATURE: ____ DATE SIGNED AND SUBMITTED: ___________

*PLEASE READ: BY SIGNING, YOU ARE VERIFYING THAT ALL INFORMATION IS TRUE, OPTICAL RECEIPTS SUBMITTED ARE FOR THE PERSON RECEIVING SERVICES AS STATED ABOVE, AND YOU HAVE NOT BEEN REIMBURSED FOR THE ABOVE OPTICAL RECEIPTS IN ANY OTHER MANNER.

ALL REIMBURSEMENT REQUESTS MUST BE ACCOMPANIED WITH PAID RECEIPTS SPECIFYING PATIENT'S NAME, DATE OF SERVICE, AND RENDERED SERVICE(S) OR GOOD(S).

RECEIPT COPIES AND/OR FAXES ARE ACCEPTABLE.
FAX: 734-955-5737 ~ Email: employeebenefits@wcaa.us

REIMBURSEMENTS MAY TAKE APPROXIMATELY 4-6 WEEKS.

RETURN CLAIM FORM AND ORIGINAL RECEIPT(S) TO:

WAYNE COUNTY AIRPORT AUTHORITY
ATTN: HR/BENEFITS & COMPENSATION
L.C. SMITH BUILDING-MEZZANINE
DETROIT, MICHIGAN 48242
734-247-3236