

Health & DC 37 Security Plan

D.C. 37 HEALTH & SECURITY PLAN LOST OPTICAL VOUCHER

Social Security Number: _____

Name of Member: _____

Address: _____

Number of Voucher(s): _____ Dates of Voucher(s) _____

Name of Claimant: _____

We have become aware that you no longer possess your Optical voucher issued to you by the DC 37 Health & Security Plan. Please complete the lower portion of this form and have it notarized. Return the completed form to the Optical Claims Department. **THIS WILL ENABLE US TO ISSUE A DUPLICATE VOUCHER FOR YOU.**

This is to certify that: (Please place an "X" in the box indicating statement which describes the circumstances).

- I have not received the described voucher.
- I received and lost the above described voucher.
- I received and destroyed the above described voucher.

IN WITNESS WHEREOF I have hereunto set my hand and seal this _____ day of _____, 19__.

Claimant's Signature

STATE OF NEW YORK)

SS:

COUNTY OF _____)

On this _____ day of _____, 19__, before me personally appeared _____, to me known and known to me to be the individual described in and who executed the foregoing instrument and duly acknowledged to me that he/she executed the same.

HS:OPT 10
(REV;7/99)

Notary Public