

Metropolitan St. Louis Sewer District

Vision Plan

Claim Form

PART 1 - COMPLETE FOR ALL CLAIMS

Social Security Number	Last Name	First Name	Middle Name/Initial
* Street or P. O. Box (COMPLETE ONLY IF RECENTLY CHANGED)		* Phone Number	
* City	* State	* Zip Code	
EMAIL Address (If Changed)			

* Complete the address and phone number section only if recently changed.

PART 2 - COMPLETE FOR VISION PLAN CLAIM

Date of Service	Provider of Service	Dollar Amount Claimed
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

PART 3 - ACKNOWLEDGMENT AND SIGNATURE

I hereby certify the claims I've submitted on this form are for me (the employee) only. I also certify the information I have provided on this form is accurate to the best of my knowledge.

Employee Signature _____ Date

FAX or Mail Signed and Dated Form with Supporting Documentation To:

Tri-Star Systems	PHONE (314) 576-4022
ATTN: Claim Department	TOLLFREE (800) 727-0182
14323 South Outer 40 Road	CLAIM FAX (314) 985-0277
Suite 200 South	
Chesterfield, MO 63017-5734	