125 Barclay St., New York, N.Y. 10007-2179 ● Telephone: (212) 815-1234

Health & DC37 Security Plan

DC 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 the 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.

IF THE ABOVE VOUCHER IS USED IN THE FUTURE, THE MEMBER WILL BE RESPONSIBLE FOR PAYMENT.

Replace Voucher?

☐ YES ☐ NO

_____
Member's Signature

Sworn to me this_____ day of

_____, 20____,

_____
Notary Public

HS:OPT 10
(REV: 6/2000)