Group No.: DAC450S

Employer:
Greenwich Hospitality Corporation

Vision Expense Reimbursement Claim Form

Employee Name ________________ Social Security Number or Member ID

Street Address

Patient's Name (if for a Dependent) ________________ Relationship ________________ Date of Birth

I hereby certify that the information on this form is complete and accurate to the best of my knowledge. I also agree to reimburse my employer to the extent of any overpayment, which is in excess of the amounts payable under this Plan.

Employee's Signature ________________ Date

How to file a Claim under the Vision Expense Reimbursement Plan:

Step 1) Complete the above Vision Expense Reimbursement Claim Form.

Step 2) Sign and date the Claim Form.

Step3) Attach itemized vison receipt(s).

Step 4. Mail your claim to: Diversified Administration Corporation
Claims Department
P.O. Box 299
Marlborough, CT 06447

Or email a copy to: bkuczynski@diversifiedgb.com