Revised 02/06/2024

Phone: 918-791-6025
Fax: 918-786-9245

Benefits Department
PO Box 453220
Grove, OK 74345

Email:
benefits@sctribe.com

CHECK THIS BOX IF YOU ARE A 1st TIME APPLICANT ☐

Benefit Application for OPTICAL

Submit to the above Address – "Attention: Benefits"

APPLICATIONS MUST BE COMPLETE OTHERWISE THEY WILL NOT BE PROCESSED

All applications will be processed according to the date the claim is received in our office.
Your claim must show the amount paid by your insurance company, if applicable.

The maximum amount paid per Tribal Member for Optical Claims is $750.00 Per Fiscal Year depending on funding availability

☐ **If you have a new address, check this box to update your address with ALL departments of the Nation.**

____
Date

Name ______ **Roll #** ______ **Date of Birth** ______

Address ______ **City/State** ______ **Zip Code** ______

Phone Number ______ **Cell Number** ______ **Work Number** ______

Email Address ______

Amount Applying for Optical $ ____________

All information provided on this form is true and complete to the best of my knowledge. If asked by an authorized official, I agree to provide proof of the information I have provided on this form. I agree to notify the Seneca-Cayuga Benefits Department of any changes in the above information.

PERMISSION FOR RELEASE OF INFORMATION

I, the undersigned tribal member do hereby give my permission for the release of vendor information to the Seneca Cayuga Nations Benefit Department. This shall include, but not be limited to landlord payments, landlord leases, dental, vision, optical receipts, utility vendors, and any other documents submitted. Any tribal member found to be defrauding the Seneca Cayuga Nation Benefit Program will be suspended indefinitely. Disrespectful behavior to Seneca Cayuga Employees shall also be cause for suspension.

____
Printed Name of Applicant or Guardian **Date**

____
Signature of Applicant or Guardian **Date**

The following documents Must be Submitted with this Application:

- A copy of the tribal card for the member applying for services.
- The invoice or statement from the doctor's office showing the amount **(must include Tribal Member's Name)**
  Note: *If the bill was paid by the Tribal Member or parent, a statement showing the amount must be provided by the doctor's office in order to be reimbursed*
- Signed application by the Tribal Member. (parent or guardian if a minor)
- W-9 Tax Form from the doctor's office. Payment will be made directly to the doctor's office

CONFIDENTIAL