SENECA - CAYUGA NATION

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:

* $750.00 Per Fiscal Year depending on funding availability

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 indefinitely.

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
  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