PRESCRIPTION EYEGLASSES REPLACEMENT FORM

An application for workers compensation benefits has been submitted by your employer to SSIF. This form pertains only to your prescription eyeglasses.

Name: _____Accident Date: _____

Home Address: _____

Employed by: _____Supervisor's Name:_____

Name and address where services will be provided: _____

Before this incident, when was your last vision exam and by whom?_____

Check the portion below that pertains to your glasses:

Frames

	Broken	Bent	Repaired	Replaced
Metal				
Plastic				

Lens

	Pitted	Broken	Scratched	Replaced
Right				
Left				

Lens

Glass	Photo-Gray	Plastic	Tint	Bifocal	Tri-Focal	No-lines

Name and address of the provider where you purchased your new glasses:_____

Did you have your eyes examined? If so, by whom: _____

List any special features(scratch-resistant finish, oversized lenses, etc): _____

Return Completed Form To:

State Self Insurance Fund
Mills Building, Suite 600
109 SW 9th Street
Topeka, Kansas 66612

Or Contact Us At:

Phone (785) 296-2364
Fax (785) 296-6995