REPLACEMENT OF PRESCRIPTION EYEGLASSES

An application for workers compensation benefits has been submitted by your employer to the State Self Insurance Fund (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
Rm. 900-N, Landon State Office Bldg.
900 SW Jackson Street
Topeka, Kansas 66612

CONTACT US BY:

785-296-2364 - PHONE
785-296-6995 - FAX