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

Form WC-00
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