



FIREFIGHTER'S RELIEF ASSOCIATION

☐ Regular Glasses Reimbursement

☐ Glasses Broken **ON DUTY**

**KANSAS CITY KANSAS FIREFIGHTER'S RELIEF ASSOCIATION
EYEGLOSS REIMBURSEMENT CLAIM FORM**

NAME: _____ Phone: _____

ADDRESS: _____ ZIP: _____

Attach original paid receipts. Reimbursement will be for up to \$350 for eyeglasses, exams, contacts, or LASIK every 24 months. The KCKFRA will reimburse each member for up to \$350 for replacement of glasses broken on duty as necessary.

If reimbursement for Glasses Broken On Duty, please provide narrative of how glasses were lost or broken including how and where:

Claimant's Signature: _____

Date: _____

Submit completed form with receipts to the KCKFRA Treasurer by email or fax:

Email: **KCKFRAClaims@gmail.com**

Fax: **913-904-0857**

Administrative Use Only

Regular Reimbursement:

Date of Last Reimb.: _____

Total Out of Pocket: _____

Total Approved Regular

Reimbursement: _____

Lost or Broken ON DUTY:

Date of Last Reimb: _____

Total Out of Pocket: _____

Total Approved On Duty

Reimbursement: _____