

LOCAL UNION 831

EMPLOYER HEALTH & WELFARE TRUST FUND

Mail to: LOCAL UNION 831
Employee Health & Welfare Trust Fund
P.O. Box 5528
El Monte, CA 91734
(626) 279-3080

Statement of Claim for Group Vision Expense Benefits

PART 1. TO BE COMPLETED AND SIGNED BY THE PERSON CLAIMING BENEFIT FOR SELF OR DEPENDENT ONLY AFTER PART 2 HAS BEEN FULLY EXECUTED. (PLEASE PRINT)

Employee's Name (First) _____ (Last) _____		Employee Date of Birth _____	Name of Company You Work For (Firm Name) _____	
Home Address (Name and State) _____		Date Employed _____	Occupation _____	
(City) _____	(State) _____	(Zip Code) _____	Employee's Telephone Number _____	Social Security Number _____
Claim is Made For: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Name of Person Receiving Vision Care (First) _____ (Last) _____		Person Receiving Vision Care: <input type="checkbox"/> Male <input type="checkbox"/> Female, Year of Birth _____	
Name and Address of Spouse's Employer _____			Does Spouse have Vision Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of any other Insurance Carrier or Organization providing benefits for Vision Care including dependent's insurance _____				
Was Vision Care required because of an Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, COMPLETE QUESTIONS BELOW.				
Was injury caused by your work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you filed a claim for this disability with the Workers' Compensation Carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is Vision examination required as a condition of your employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	

The above answers are true and complete according to the best of my knowledge. I hereby authorize my doctor to furnish and disclose all facts concerning this disability. I certify that the examinations stated in PART 2 below have been made, the materials described therein furnished, and professional services described therein rendered, all in a manner satisfactory to me.

I do do not hereby authorize payment directly to the undersigned doctor of the Vision Care benefits otherwise payable to me and to the supplying or dispensing optician for the ophthalmic materials and related charges according to the attached invoice.

EMPLOYEE SIGN HERE

Date _____ Signature of _____

PART 2. TO BE COMPLETED BY DOCTOR

1. Has patient worn glasses before this examination? Yes No. Type _____ Date of Prev. Exam. _____
2. If Yes, state reason for replacement _____
3. Does your examination indicate that glasses should be prescribed? Yes No
4. If you prescribe glasses, check type: Single Vision Bifocal Trifocal
Other (Describe) _____
5. Has cataract surgery been performed? Yes No. Date _____
6. Can visual acuity be restored to at least 20/70 in the better eye with conventional glasses? Yes No

	Date of Service	Charges		Date Service Began _____	Date Service Completed _____
		\$	c		
7. EXAMINATIONS				Doctor's Name _____	
A Vision Survey				Doctor's Address _____	
B Complete Visual Analysis (With Tonometry)				I hereby certify that examinations have been completed and materials and services rendered as stated in this Part 2.	
C Complete Visual Analysis (Without Tonometry)					
8. MATERIALS & PROFESSIONAL SERVICES				Doctor's Signature X _____	
A Single Vision Lenses				Date _____	
B Bifocal Lenses				Taxpayers or Social Security Number _____	
C Trifocal Lenses					
D Lenticular Lenses					
E Contact Lenses, for Each Lens					
F Frame					
G Case					
	TOTAL				

EMPLOYER'S STATEMENT

1. Effective Date of employee's coverage _____ Plan No. _____
Effective Date of dependent's coverage _____
2. Has coverage terminated? Yes No. If yes, give date and reason _____ 19 _____

Dated _____ Signed for Employer: _____ Title _____