

**Statement of Claim
for Group Vision
Expense Benefits**

**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

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	Name of Person Receiving Vision Care (First) (Last)	Person Receiving Vision Care	
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		<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? Yes 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 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

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

7. EXAMINATIONS	Date of Service	Charges		Date Service Began	Date Service Completed
		\$	c		
A. Vision Survey					
B. Complete Visual Analysis (With Tonometry)					
C. Complete Visual Analysis (Without Tonometry)					
8. MATERIALS & PROFESSIONAL SERVICES					
A. Single Vision Lenses					
B. Bifocal Lenses					
C. Trifocal Lenses					
D. Lenticular Lenses					
E. Contact Lenses, for Each Lens					
F. Frame					
G. Case					
TOTAL					

Doctor's Name _____
Doctor's Address _____
I hereby certify that examinations have been completed and materials and services rendered as stated in this Part 2.
Doctor's Signature X _____
Date _____
Taxpayers or Social Security Number _____

EMPLOYER'S STATEMENT

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

Dated _____ Signed for Employer _____ Title _____