L.A. (626) 288-6115
S.D. (858) 530-0270
FAX NO: (626) 288-0161

LOCAL UNION 831

TRADESHOW AND SIGN CRAFTS,
I.U.P.A.T.-A.F.L.-C.I.O.

3360 Flair Drive., Suite 101
El Monte, CA 91731
www.local831.org

September 10

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

SEPTEMBER 2010 SHOW SCHEDULE

WE NEED A CURRENT EMAIL ADDRESS. SEND YOUR INFORMATION TO: email@local831.org

October 10

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

HEALTH INSURANCE ALERT – LEVELS MAY NEED TO BE LOWERED – CALL THE UNION OFFICE FOR ASSISTANCE

MOVE IN	START		END	SHOW NAME	LOCATION	HALL/BOOTH	COMPANY
Aug 26	08/29	-	08/31	NACDS PHARM & TECH CONF	SDCC	A-C 300	GESSD
Aug 27	08/28	-	08/29	EDVANT EXPO	LACC	150	FDC
AUGUST 30TH(MONDAY)GENERAL MEMBERSHIP MEETING/5:00PM/IAM HALL/5150 KEARNY MESA RD,SAN DIEGO							
Sep 02	09/03	-	09/05	SCRC	ACC	100	BLAINE
SEPTEMBER 6TH (MONDAY) -LABOR DAY- UNION HOLIDAY							
Sep 07	09/08	-	09/08	APARTMENT ASSOCIATION SO CA	LBCC	150	TOTAL EXPO
Sep 09	09/10	-	09/11	HISPANIC CHAMBER OF E-COMMERCE	SDCC	140	GESSD
Sep 09	09/10	-	09/12	ADULTCON	LACC	100	BLAINE
Sep 10	09/11	-	09/12	NORTH AMERICAN REPTILE CONF	ACC	150	FDC
Sep 10	09/14	-	09/16	AIRCRAFT INTERIORS	LBCC	175	FDC
Sep 10	09/14	-	09/16	WORLD AIRLINE ENTERTAINMENT	LBCC	160	FDC
Sep 11	09/12	-	09/14	HEART FAILURE SOC OF AMERICA	SDCC	120	FDC
Sep 11	09/12	-	09/16	SYMITAR ANNUAL EDUCATIONAL CONF	SD HYATT	100	GESSD
Sep 13	09/14	-	09/16	PAINT BALL	OC HYATT	120	CDS
Sep 13	09/15	-	09/15	SYSCO FOODS	ACC	**B 500**	BLAINE
Sep 13	09/15	-	09/16	IFSA	LBCC	115	FDC
Sep 14	09/14	-	09/18	SAN DIEGO QUILT SHOW	SDCC	H 100	GESSD
Sep 15	09/16	-	09/17	LEAGUE OF CALIFORNIA CITIES	SDCC	150	GESSD
SEPTEMBER 15TH(WED) GEN MEMBERSHIP/STEWARD MEETING/6:00PM/UFCW HALL/8530 STANTON AVE,BUENA PARK							
Sep 17	09/23	-	09/24	NATIONAL BLACK MBA	LACC	**750**	FDC
Sep 18	09/18	-	09/20	HACU	HILTON BAY FRONT SD	150	CDS
Sep 18	09/19	-	09/21	DISASTER RECOVERY JOURNAL FALL WORLD	SHERATON SD	PAVILION 100	GESSD
Sep 18	09/20	-	09/21	NAMIC	SD HYATT	110	FDC
Sep 19	09/20	-	09/21	EMPLOYER HEALTHCARE CONGRESS	CENTURY PLAZA	125	FDC
Sep 20	09/22	-	09/23	PHRA	PASADENA CC	A & B 160	GESLA
Sep 20	09/23	-	09/24	ICSC WESTERN DIVISION CONFERENCE	SDCC	**850**	GESSD
Sep 21	09/22	-	09/24	WORLD MEDICAL TOURISM	CENTURY PLAZA	125	FDC
Sep 21	09/22	-	09/24	SYMP ON ADVANCED WOUND CARE	ACC	160	FDC
Sep 21	09/24	-	09/26	LONG BEACH COIN	LBCC	400	FDC
Sep 23	09/26	-	09/27	ESTHETICS SHOW	LBCC	280	EXHIBITS WEST
Sep 27	09/28	-	09/30	L A INTERNATIONAL TEXTILE FAIR	LACC	A WEST 300	GESLA
Sep 27	09/29	-	09/29	MAES	ANAHEIM HILTON	125	CDS
Sep 27	09/30	-	10/03	WORLD CYBER GAMES	LACC	S. SPEC EVENT	GESLA
Sep 28	09/29	-	10/02	INTERNATIONAL ASSN OF MOVERS	SD HYATT	110	GESSD
Sep 28	09/30	-	10/02	AUGS	LBCC	120	CHAMPION
Sep 30	10/01	-	10/02	GROW 2010 LA	LACC	B 250	BLAINE
Oct 02	10/03	-	10/05	WEST COAST JEWELERY SHOW	PASADENA CC	150	FDC
Oct 03	10/05	-	10/07	CALIFORNIA ASSN OF REALTORS	ACC	A & B 280	GESLA
Oct 03	10/06	-	10/07	WORKPLACE ADVOCATES SUMMIT	LACC	A&B WEST 125	GESLA

**Show dates indicated are as furnished and are subject to change.*

- Out of Work? Call the Union Office Between 8:00 a.m.-- 12:00 noon: LOS ANGELES **(626) 288-0390**/ SAN DIEGO **(858) 530-0270**
- Questions regarding health insurance eligibility, dental or vision coverage, retirement and/or pension information should be directed to the:

LOCAL 831 HEALTH & PENSION TRUST FUND at **(877) 572-7005**

CHECK OUT THE LOCAL 831 WEB SITE: **http://www.local831.org**

EI COMPANIES AND HIRE PHONE NUMBERS
TRADESHOW & SIGN CRAFTS LOCAL UNION 831
- Out of Work? Call the LU 831Office Between 8:00 a.m.-- 12:00 noon: L.A. (626) 288-0390/ S.D. (858) 530-0270

EMPLOYER NAME	ADDRESS	CITY	STATE	ZIP	WORK LINE	HIRING FOREMAN
ABSOLUTE I & D, INC.	9412 WALKER RANCH CIRCLE	VILLA PARK	CA	92861	714-685-8950	ALAN KOREN
AEI I&D, LLC *	21562 NEWLAND ST.	HUNTINGTON BEACH	CA	92646	714-594-5784	JOHN PASS
BACHIERO EVENT SERVICES, LLC.	23213 ANZA AVE.	TORRANCE	CA	90505	310-465-0553	ANTHONY BACHIERO
BLAINE CONVENTION SERVICES	114 S. BERRY STREET	BREA	CA	92821	714-522-8270, ext. 237	STEVE MARGOS
CARDEN CONVENTION SERVICE	1180 N. MARSHALL AVE. #B	EL CAJON	CA	92020	619-448-1929	
CHAMPION EXPOSITION SERVICES *	14701 INDUSTRY CIRCLE	LA MIRADA	CA	90638	714-735-5361	A. COVARRUBIAS
COASTAL INTERNATIONAL CON SVC*	1652 EDINGER, SUITE A	TUSTIN	CA	92780	714-635-1200	ROBERT L. HILL
CONVENTION DECORATING SVC INC*	6245 DESCANSO AVE.	BUENA PARK	CA	90620	714-880-1176	DOUG EMERSON
CSI WORLDWIDE, LLC *	500 CHANEY ST. SUITE H	LAKE ELSINORE	CA	92530	951-471-1011	ALEX HILL, V
CUSTOMER SERVICE I&D, INC.	7178 PINTAIL DRIVE	CARLSBAD	CA	92011	760-259-2012	JOSEPH HARMON
CZARNOWSKI DISPLAY SERV,INC. *	2250 SOUTH YALE ST, #A	SANTA ANA	CA	92704	714-437-5330	SHAWN CRAWFORD
EAGLE MANAGEMENT GROUP, INC*	1717 N. TYMPANI CIRCLE	ANAHEIM	CA	92807	714-970-0034	RAFAEL VAZQUEZ
EVENT PRODUCTIONS, INC.	651 WEST TOWER AVE.	ALAMEDA	CA	94501	510-263-0228	RICHARD EGAN
EXHIBIT INSTALLATIONS SPEC*	126 E. 60TH ST.	LONG BEACH	CA	90805	909-322-4088	KEVIN WITHROW
EXHIBIT INSTALLATIONS, INC.	9830 NORWALK BLVD. STE. 170	SANTA FE SPRINGS	CA	90670	562-944-6022	CATHY COLLOSI
EXHIBIT SERVICES WEST, INC.	5277 N. VINCENT AVE. #19	IRWINDALE	CA	91706	626-226-5939	MARK GRINSTEAD
EXHIBITS WEST EXPO SERVICES	1365 E. HILL ST.	SIGNAL HILL	CA	90715	562-243-3355	ANTHONY MATTOX
EXPO SERVICES, U.S.A. *	5560 KATELLA AVENUE	CYPRESS	CA	90630	562-356-3781	PAT GALLAGHER
FOCUS EXHIBITS & TS SERVICES	13700 STOWE DR.	POWAY	CA	92064	858-967-5893	EDGAR GARCIA
FREEMAN DECORATING CO *	901 E. SOUTH ST.	ANAHEIM	CA	92805	714-254-3401	MATT KARI
FREEMAN DECORATING COMPANY	6060 NANCY RIDGE DR STE#C	SAN DIEGO	CA	92121	858-320-7880	STEVE MARTIN
GALAXIE DISPLAYS, INC.	5241 LINCOLN AVE. SUITE B6	CYPRESS	CA	90630	714-828-2848	DAVID KATAYAMA
GES EXPOSITION SERVICES	491 C STREET	CHULA VISTA	CA	91910	619-498-6314	TIM GRAHAM
GES EXPOSITION SERVICES**	5560 KATELLA AVE.	CYPRESS	CA	90630	562-370-1634	JACK BARNES
HARRINGTON EXPOSITION SVCS INC	4843 WHIPPOORWILL LANE	BONITA	CA	91902	619-454-3494	TOM HARRINGTON
INNOVATIVE EXPO, INC.	72-242 WATT COURT	THOUSAND PALMS	CA	92276	760-343-2555	JIM PATE
INTERNATIONAL EXPO SERVICE INC	10741 WALKER STREET	CYPRESS	CA	90630	714-763-4400	CHRISTINA COLLIN
LASER EXHIBITOR SERVICE	32236 PASEO ADELANTO SUITE E	SAN JUAN CAPISTR	CA	92675	949-248-1844	JAMES JONES
MCNABB COMPANY	31250 S. MILFORD RD	MILFORD	MI	48381	714-467-6814	ROBERT ONSUREZ
MOMENTUM MANAGEMENT, INC*	1490 MOUNTAIN MEADOW DR.	OCEANSIDE	CA	92656	760-295-7575	MATT CORNELL
NATIONAL CONVENTION SERVICES*	1325 HILL STREET	SIGNAL HILL	CA	90755	562-592-1250	BOB MASSE
NATIONWIDE SERVICES, LLC.	2519 CAROLYN DRIVE	SMYRNA	GA	30080	866-768-1752	JULES SCHOICKET
NTH DEGREE*	14711 BENTLEY CIRCLE, SUITE A	TUSTIN	CA	92780	714-508-5199	RUBEN LUNA
NUVISTA EVENT SERVICES *	21474 LA CAPILLA	MISSION VIEJO	CA	92691	949-600-8741	CHRIS WAGONER
ON LOCATION, INC. *	8585 WESTERN AVENUE "C"	BUENA PARK	CA	90620	714-761-1970	DAVID POST
PROF. EXHIBITORS SERVICE, INC*	3422 CONRAD AVE.	SAN DIEGO	CA	92117	619-258-5503	JEFFREY BRAUER
RENAISSANCE MANAGEMENT INC *	1265 NO. MANASSERO ST, # 305	ANAHEIM	CA	92807	714-777-1215	MIKE KADOW
S&N SHOW SERVICES, INC DBA	8281 MONROE AVE.	STANTON	CA	90680	714-484-6708	DONALD NEAL
SAN DIEGO EXHIBITOR SHW SV INC	6455 WEATHERS PLACE	SAN DIEGO	CA	92121	858-552-9033	JERON HARRISON
SHEPARD EXPOSITION SERVICES *	12707 RIVES AVE. SUITE C	DOWNEY	CA	90242	714-494-4667	JEFFREY GEORGE
SHO AIDS, INC. *	1180 N. MARSHALL DR. STE. B	EL CAJON	CA	92020	760-722-3771	JACK WHITTAKER
SHO-LINK, INC. *	7522 SLATER AVE SUITE 125	HUNTINGTON BEACH	CA	92647	714-596-6679	JIM GENZANO
SHOW READY *	2000 POMONA BLVD. UNIT A	POMONA	CA	91768	909-595-2616	DOUG MURPHY
SHOW SERVICES, LLC. *	4642 VALENCIA	YORBA LINDA	CA	92686	800-737-8757	JON FORD
SHOWPROS LLC *	4075 E. LA PALMA AVE., STE T	ANAHEIM	CA	92807	407-437-8756	JOSHUA COX
SKYLINE CONVENTION SERVICES	10420 PIONEER BLVD. #A	SANTA FE SPRINGS	CA	90670	562-547-4901	THEODORE ALCARAZ
SKYLINK SHOW SERVICES	25151 ARCTIC OCEAN DR.	LAKE FOREST	CA	92630	949-900-3000	JOHN BALDERRAMA
THE TRADE EVENT RES MGM GRP *	11264 MONARCH ST. UNIT A	GARDEN GROVE	CA	92841	714-899-3127	T.J. SYLVIA
TOTAL EXPO, INC.	1161 SANDHILL AVE., UNIT D	CARSON	CA	90746	310-320-4203	JON LECARNER
TRADE SHOW SPECIALIST CORP*	17909 FITCH	IRVINE	CA	92614	949-225-0112	ADAM SUISSA
TRADESHOW SERVICES NETWORK,LLC	2865 WESTRIDGE RD.	RIVERSIDE	CA	92506	909-816-5663	D. ERIC MCMORRIS
TRIDENT EXPOSITION SRVCS, LLC	22431 ANTONIO PKWY B160 #152	RANCHO STA MARGA	CA	92688	949-307-9833	SCOTT WEEKLEY
UNION PAYROLL AGENCY, INC.	5430 PARK DRIVE	ROCKLIN	CA	95765	916-625-1420	MATHEW WRIGHT
WILLWORK INC. *	1560 S. ANAHEIM BLVD. STE.B	ANAHEIM	CA	92805	818-645-9986	BRAD FAULKNER
YOUNG EXHIBITOR SERVICES, LLC	7292 OPPORTUNITY RD. STE. A	SAN DIEGO	CA	92111	619-873-5797	LANCE BUTZE
ZENITH LABORNET, INC. *	6061 DALE ST. UNIT A	BUENA PARK	CA	90621	714-739-0539	DOUG BRYANT

EMPLOYEE CLAIM FORM AND ATTENDING DENTIST'S STATEMENT
EMPLOYEE SECTION

LOCAL UNION 831 EMPLOYER HEALTH & WELFARE TRUST FUND

MAIL TO: LOCAL UNION 831
P.O. Box 5528
El Monte, CA 91734
(626) 279-3080

NAME AND ADDRESS OF EMPLOYER | POLICY NUMBER

EMPLOYEE'S NAME (Last, First, Middle Initial) | EMPLOYEE'S ADDRESS (No., Street, City, State, Zip Code) Is this a new address? ☐ YES ☐ NO

EMPLOYEE'S DATE OF BIRTH | SOCIAL SECURITY NUMBER | CLAIM IS FOR ☐ EMPLOYEE ☐ SPOUSE ☐ CHILD ☐ OTHER Specify

PATIENT'S GENDER ☐ MALE ☐ FEMALE | PATIENT'S DATE OF BIRTH | PATIENT'S NAME IF NOT EMPLOYEE

IF CHILD 19 OR OVER INDICATE ☐ HANDICAPPED ☐ STUDENT | IF STUDENT INDICATE NAME AND ADDRESS OF SCHOOL

ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING

NAME OF EMPLOYED FAMILY MEMBER

NAME AND ADDRESS OF HIS OR HER EMPLOYER

NAME AND ADDRESS OF HIS OR HER EMPLOYER'S INSURANCE CARRIER

IDENTIFICATION NUMBER OR POLICY NUMBER

I HEREBY AUTHORIZE RELEASE OF X-RAYS AND ANY OTHER INFORMATION RELATING TO THIS CLAIM
I declare and certify that the foregoing statements made by me are true, to the best of my knowledge and belief. I am aware that if any of the statements made by me are willfully false, I may be subject to criminal and civil penalties.

SIGNED _____
(Patient or Parent if Patient is a minor)

I HEREBY AUTHORIZE PAYMENT OF THE GROUP DENTAL BENEFITS OTHERWISE PAYABLE TO ME, DIRECTLY TO THE DENTIST NAMED BELOW

SIGNED _____
(Patient or Parent if Patient is a minor)

DENTIST SECTION

BEFORE COMPLETING READ INSTRUCTIONS ON LAST PAGE FOR CLAIM SUBMITTAL & NECESSARY NOMENCLATURE & PROCEDURE CODES

DENTIST'S NAME

MAILING ADDRESS

CITY, STATE, ZIP

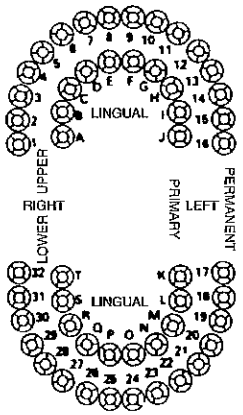
DENTIST SOC. SEC. OR T.I.N. | DENTIST LICENSE NO. | DENTIST PHONE NO.

FIRST VISIT DATE CURRENT SERIES | PLACE OF TREATMENT OFFICE HOSP. ECF OTHER | RADIOGRAPHS OR MODELS ENCLOSED? NO YES HOW MANY?

	NO	YES	
IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
IS TREATMENT RESULT OF AUTO ACCIDENT? OR OTHER ACCIDENT?			
ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) / DATE OF PRIOR PLACEMENT
IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER / DATE APPLIANCES PLACED / MOS. TREATMENT REMAINING

CHECK ONE ☐ DENTIST'S PRE-TREATMENT ESTIMATE ☐ DENTIST'S STATEMENT OF ACTUAL SERVICES PERFORMED

IDENTIFY MISSING TEETH WITH X



REMARKS FOR UNUSUAL SERVICES

EXAMINATION AND TREATMENT PLAN – LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 – USE CHARTING SYSTEM SHOWN

LINE NO.	TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO DAY YEAR	ADA PROCEDURE NUMBER	FEE	FOR ADMINISTRATION USE ONLY ☐ SCHEDULE ☐ U&C %	%
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED

SIGNED DENTIST _____ DATE _____

Administered by: A.T.P.A.

TOTAL FEE CHARGED			
MAX. ALLOWABLE			
DEDUCTIBLE			
CARRIER %			
CARRIER PAYS			
PATIENT PAYS			

Statement of Claim For Group Medical Expense Benefits

LOCAL UNION 831 EMPLOYER HEALTH & WELFARE TRUST FUND

MAIL TO: LOCAL UNION 831
P.O. Box 5528
El Monte, CA 91734
(626) 279-3080

HOW TO FILE A CLAIM

1. COMPLETE THIS SIDE OF FORM, ANSWER ALL QUESTIONS.
2. COMPLETE THE TOP PORTION OF REVERSE SIDE OF THIS FORM AND SIGN THE AUTHORIZATION TO RELEASE INFORMATION.
3. HAVE ATTENDING PHYSICIAN COMPLETE REVERSE SIDE OF FORM.
4. ATTACH ITEMIZED BILLS – **IMPORTANT** – EACH BILL MUSH SHOW:
   (1.) NAME OF PATIENT, (2.) DATE EACH EXPENSE WAS INCURRED, AND (3.) NATURE OF ILLNESS OR INJURY,
   IF THE BILL DOES NOT SHOW THIS INFORMATION, PLEASE WRITE IT ON THE BILL AND SIGN YOUR NAME.
5. FORWARD COMPLETED FORM AND BILLS TO **THE ADMINISTRATOR** IN THE SELF-ADDRESSED ENVELOPE PROVIDED.
6. **DO NOT SUBMIT ANY ON-THE-JOB INJURY OR WORKERS' COMPENSATION CLAIM.**

TO BE COMPLETED BY THE EMPLOYEE

NAME (LAST, FIRST, MIDDLE INITIAL) | **SOCIAL SECURITY NO.**

HOME ADDRESS (STREET, CITY, STATE, ZIP CODE) **IS THIS A NEW ADDRESS?** ☐ **YES** ☐ **NO** | **WEEKLY WAGE**

DATE OF BIRTH | **TELEPHONE NUMBER** | ☐ **MALE** ☐ **FEMALE** ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **SEPARATED**

NAME AND ADDRESS OF EMPLOYER

DO YOU HAVE MORE THAN ONE EMPLOYER? ☐ YES ☐ NO IF YES, GIVE NAME AND ADDRESS.

DO YOU HAVE OTHER FAMILY MEMBERS EMPLOYED? ☐ YES ☐ NO IF YES, GIVE NAME, RELATIONSHIP AND FULL NAME AND ADDRESS OF EMPLOYER.

IS THIS CLAIM FOR A DEPENDENT? ☐ YES ☐ NO IF YES, GIVE NAME, DATE OF BIRTH, RELATIONSHIP MARRIED? ☐ YES ☐ NO | **SPOUSE'S DATE OF BIRTH**

NATURE OF ILLNESS | **DATE OF FIRST TREATMENT**

IS THIS CLAIM BASED ON AN ACCIDENT? ☐ **YES** ☐ **NO IF YES, COMPLETE THE FOLLOWING:**

DATE OF ACCIDENT | TIME ☐ **AM** ☐ **PM** | **WHERE DID ACCIDENT OCCUR?**

HOW DID ACCIDENT HAPPEN?

HAS CLAIM PREVIOUSLY BEEN MADE FOR THIS PERSON UNDER THIS PLAN? ☐ YES ☐ NO

HAVE YOU (OR DEPENDENT) PREVIOUSLY BEEN TREATED FOR THIS OR A RELATED MEDICAL PROBLEM? ☐ YES ☐ NO IF YES, STATE WHEN AND GIVE NAME(S) AND ADDRESS(ES) OF DOCTOR(S) AND HOSPITAL(S)

ARE ANY OF THE ILLNESSES OR INJURIES FOR WHICH THIS CLAIM IS BEING MADE RELATED TO EMPLOYMENT? ☐ YES ☐ NO

IF YOU HAVE BEEN UNABLE TO WORK, GIVE DATE OF FIRST FULL DATE NOT WORKED ..... GIVE DATE OF RETURN OR EXPECTED DATE OF RETURN TO WORK .....

ARE YOU ENTITLED TO REIMBURSEMENT OF ALL OR PART OF THESE EXPENSES THROUGH ANY OTHER COVERAGE WHICH PROVIDES MEDICAL BENEFITS OR SERVICES? ☐ YES ☐ NO

IF YES, GIVE NAME AND ADDRESS OF ORGANIZATION PROVIDING BENEFITS OR SERVICES

I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacy to release any information requested by the Administrator or its representative. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Patient's Signature if Claim is for dependent other than minor child .....

Dated ..... **Signature of Employee-Insured** .....

To authorize payment of benefits directly to your physician, complete authorization to pay benefits section on reverse side.

Administered by: ATPA

LOCAL UNION 831
EMPLOYER HEALTH & WELFARE TRUST FUND

Statement of Claim for Group Vision Expense Benefits

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: ☐ Self ☐ Spouse ☐ Child

Name of Person Receiving Vision Care (First) (Last)

Person Receiving Vision Care: ☐ Male ☐ Female — Year of Birth

Name and Address of Spouse's Employer

Does Spouse have Vision Insurance? ☐ Yes ☐ 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? ☐ Yes ☐ No	Have you filed a claim for this disability with the Workers' Compensation Carrier? ☐ Yes ☐ No	Is Vision examination required as a condition of your employment? ☐ Yes ☐ 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 ben 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 $	Charges ¢
7. EXAMINATIONS			
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		

Date Service Began _____ Date Service Completed _____

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. _____

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

Dated _____ Signed for Employer _____ Title _____

SCL-007 (8/91) 28

Administered by: ATPA

Health Insurance Claim Form

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME *(First name, middle initial, last name)*
2. PATIENT'S DATE OF BIRTH
3. INSURED'S NAME *(First name, middle initial, last name)*
4. PATIENT'S ADDRESS *(Street, city, state, ZIP code)*
5. PATIENT'S GENDER — MALE / FEMALE
6. INSURED'S I.D. NO.
7. PATIENT'S RELATIONSHIP TO INSURED — SELF / SPOUSE / CHILD / OTHER
8. INSURED'S GROUP NO. *(Or Group Name)*
9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number
10. WAS CONDITION RELATED TO:
    A. PATIENT'S EMPLOYMENT — YES / NO
    B. AN AUTO ACCIDENT — YES / NO
11. INSURED'S ADDRESS *(Street, city, state, ZIP code)*
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
    I AUTHORIZE THE RELEASE O ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM
    I declare and certify that the foregoing statements made by me are true to the best of my knowledge and belief. I am aware that il any of the statements made by me are willfully false I may be subject to criminal and civil penalties
    SIGNED *DATE*
13. *I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW*
    SIGNED (Insured or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES / NO
17. DATE PATIENT ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY — FROM / THROUGH
    DATES OF PARTIAL DISABILITY — FROM / THROUGH
19. NAME OF REFERRING PHYSICIAN
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES — ADMITTED / DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES / NO
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN BY REFERENCE TO NUMBERS 1, 2, 3, ETC OR DX CODE
    1
    2
    3

☐ Check here if for Second Surgical Opinion

24. A DATE OF SERVICE	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE (IDENTIFY)	*(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)*	D DIAGNOSIS CODE	E CHARGES	F

25. SIGNATURE OF PHYSICIAN OR SUPPLIER
26. YOUR SOCIAL SECURITY NO.
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. YOUR EMPLOYER ID NO.
31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & *TELEPHONE NO.*
    SIGNED DATE
32. ARE YOU BOARD CERTIFIED? YES NO
33. YOUR PATIENT'S ACCOUNT NO.
34. SPECIALTY
    I.D. NO.

* PLACE OF SERVICE CODES

1 — (IH) — INPATIENT HOSPITAL
2 — (OH) — OUTPATIENT HOSPITAL
3 — (O) — DOCTOR'S OFFICE
4 — (H) — PATIENT'S HOME
5 — DAY CARE FACILITY (PSY)
6 — NIGHT CARE FACILITY (PSY)
7 — FREE STANDING SURGICAL CTR
8 — (SNF) — SKILLED NURSING FACILITY
9 — AMBULANCE
O — (OL) — OTHER LOCATIONS
A — (IL) — INDEPENDENT LABORATORY
B — IMMEDIATE CARE CENTER