

RETURN
COMPLETED
FORM TO:

SHEET METAL WORKERS LOCAL 263
HEALTH AND WELFARE FUND
150 First Avenue NE Suite 450
Cedar Rapids, IA 52401
319-365-2810

VIS. 1.1



VISION CARE BENEFITS

EMPLOYEE INFORMATION - REQUIRED for all claims

Home Local Union No. _____

Name of Employee _____ Date of Birth _____
(Last) (First) (Middle)

Employee's Marital Status: Single _____ Married _____ Widowed _____ Divorced _____ Separated _____

Social Security No. _____ Occupation _____ Active Retired

Street Address _____

City, State _____ Zip _____ Phone number () _____

DEPENDENT INFORMATION - If Claim is For Your Dependent

Name of Dependent _____

Relationship to Employee _____ Date of Birth _____

Dependent's Marital Status: Single _____ Married _____ Widowed _____ Divorced _____ Separated _____

IS DEPENDENT EMPLOYED? IF YES, NAME _____
 YES NO ADDRESS _____
CITY, STATE _____ ZIP _____

IS DEPENDENT ATTENDING SCHOOL? IF YES, NAME _____
 YES NO ADDRESS _____
CITY, STATE _____ ZIP _____

NOTE: Attach letter from the school with certified transcript stating that Dependent is a full-time student.

OTHER INSURANCE INFORMATION

Do you or your Dependents have ANY other health insurance? YES NO IF YES, FAMILY SINGLE

A) Name of the person insured _____ Relationship to Employee _____

B) Insured person's employer _____

C) Employer's street address _____

City, State _____ Zip _____

D) Policy number _____ Certificate number _____ Social Security number _____ Phone number () _____

NOTE: Attach copy of payment worksheet or denial from other insurance or Medicare.

AUTHORIZATION

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release, when requested by the Trustees or their representative, of any facts concerning the treatment of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original.

Employee's Signature _____ Date _____

Patient's Signature _____ Date _____

ASSIGNMENT

I hereby authorize payment of Vision Care Benefits directly to the provider(s) of services and materials described on the reverse side of this form.

Employee's Signature _____

Date _____

TO BE COMPLETED BY OPHTHALMOLOGIST OR OPTOMETRIST

PATIENT'S NAME _____ AGE _____

1. Indicate the nature of eye examination: Initial Exam Continuing Care
 Complete examination, including eye refraction. Date of Exam _____ Fee \$ _____
 Complete examination, excluding eye refraction. Date of Exam _____ Fee \$ _____

2. Has patient previously had glasses? YES (Give Date _____) NO

3. Does patient require a prescription change at this time? YES NO

4. Were tinted lenses prescribed? YES NO

5. Are these lenses to be used primarily as sunglasses? YES NO

6. Materials prescribed or provided:

| | | | ONE | TWO | EACH | TOTAL |
|------------------------|----------|----------------------|--------------------------|--------------------------|----------------|----------|
| FRAMES | \$ _____ | LENSES-SINGLE VISION | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____ | \$ _____ |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| SUB-NORMAL VISION AIDS | \$ _____ | LENSES-BIFOCAL | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____ | \$ _____ |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | | LENSES-TRIFOCAL | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____ | \$ _____ |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | | LENSES-LENTICULAR | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____ | \$ _____ |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | | LENSES-CONTACT | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____ | \$ _____ |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | | | | | TOTAL \$ _____ | \$ _____ |

7. Are frames or lenses being replaced as a result of breakage, or loss? (Circle One) Frames: YES NO Lenses: YES NO

8. If contact lenses are being prescribed, please answer the following:

- a) Are these lenses for cosmetic purposes? YES NO
 b) Is this the first pair following cataract surgery? YES NO (If YES provide the date of surgery _____)
 c) Would the visual acuity be corrected to 20/70 in better eye by use of conventional lenses? YES NO
 d) Will the use of contact lenses correct the visual acuity to 20/70 or better? YES NO

DOCTOR'S SIGNATURE DEGREE DATE

PRINT OR TYPE DOCTOR'S NAME TAX I.D. NO. TELEPHONE NO.

STREET ADDRESS CITY STATE ZIP

TO BE COMPLETED BY OPTICIAN OR LAB

1. Materials prescribed or provided:

| | | | ONE | TWO | EACH | TOTAL |
|------------------------|----------|----------------------|--------------------------|--------------------------|----------------|----------|
| FRAMES | \$ _____ | LENSES-SINGLE VISION | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____ | \$ _____ |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| SUB-NORMAL VISION AIDS | \$ _____ | LENSES-BIFOCAL | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____ | \$ _____ |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | | LENSES-TRIFOCAL | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____ | \$ _____ |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | | LENSES-LENTICULAR | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____ | \$ _____ |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | | LENSES-CONTACT | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____ | \$ _____ |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | | | | | TOTAL \$ _____ | \$ _____ |

2. Date service began _____ 3. Date service completed _____

PROVIDER'S SIGNATURE DATE

PRINT OR TYPE PROVIDER'S NAME TAX I.D. NO. TELEPHONE NO.

STREET ADDRESS CITY STATE ZIP