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 ○ Self ○ Spouse ☐ Child

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

Person Receiving Vision Care 3 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?	Have you filed a claim for this disability with the Workers' Compensation Carrier?	Is Vision examination required as a condition of your employment?
○ Yes ☐ No	☐ Yes ☐ No	☐ 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 EJ No

	Date of Service	Charges $	c
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 _____

Administered by: Pacific Southwest Administrators