

Plumbers and Steamfitters Local 43 Health and Welfare Fund

2187 Northlake Parkway
Suite 106, Building 9
Tucker, Georgia 30084-4149

APPLICATION FOR
VISION CARE BENEFITS

Part 1. To Be Completed and Signed by Employee (Please Print)

EMPLOYEE'S NAME (FIRST) (LAST)		NAME OF COMPANY YOU WORK FOR (FIRM NAME)		LOCAL UNION NO.
HOME ADDRESS (NUMBER AND STREET)		DATE EMPLOYED	OCCUPATION	
CITY (STATE) (ZIP CODE)		HOME TELEPHONE NO.	SOCIAL SECURITY NO.	
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	DATE OF BIRTH OF PERSON RECEIVING VISION CARE
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 DEPENDENTS' 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 WORKMEN'S 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 and belief. I hereby authorize my doctor to furnish and disclose all facts concerning this disability.			EMPLOYEE SIGN HERE	AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
Date _____ Signature _____		SIGNED (Insured or Authorized Person)		

Part 2. To Be Completed by Doctor

- Has patient worn glasses before this examination? _____ Type _____
If yes, state reason for replacement _____
- If you prescribed 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? _____
- Are existing frames being used for the new glasses? Yes No If no, why not? _____

INS. CLASS	DEGREE	DOCTOR LIC. NO.	CLMT.	STATE TRT.	ZIP TREATED	ICDA	CPT	AUDITOR NO.	DATE OF AUDIT
/	/	/	/	/	/	370	/	/	/
EMPLOYEE (LAST-FIRST-ZIP)					DATE OF BIRTH	DEPENDENT NAME AND RELATIONSHIP		DATE OF BIRTH	COV. <input checked="" type="checkbox"/> V
PROFESSIONAL SERVICES					FOR ADMINISTRATIVE USE ONLY				
VISION SURVEY	1A/								
VISUAL EXAM W/O TONOM.	1B/								
VISUAL EXAM W/TONOM.	1C/								
SINGLE VISION LENSES	1D/								
BIFOCAL LENSES	1E/								
TRIFOCAL LENSES	1F/								
LENTICULAR LENSES	1G/								
CONTACTS, EACH LENS	1H/								
FRAME SERVICE	1J/								
OTHER	/								
OTHER	/								
ATTACH ITEMIZED BILLS		Subtotal							
		Tax							
		TOTAL							
COORDINATION OF BENEFITS		AMOUNT	C.O.B.	BALANCE DUE	No. of Dfs. This Audit				
80/	/	/	/	/	8				

Part 3. To Be Completed by Administrator

- Was the employee eligible for insurance and was insurance in force at time this claim commenced?
 Yes No
- Months eligible _____
- Date _____
Signed _____

SIGNATURE BY THE DOCTOR CERTIFIES THAT ALL SERVICES LISTED ABOVE HAVE BEEN COMPLETED.

Date _____ Signed _____ (DOCTOR)

Individual Practitioners - SS No. _____
All Others - Employer I.D. No. _____

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(TYPE OR PRINT DOCTOR'S NAME)

(DEGREE)

License Number _____

Phone _____ Address (NUMBER AND STREET) (CITY) (STATE) (ZIP CODE)