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CONSTRUCTION INDUSTRY LABORERS WELFARE FUND

116 COMMERCE DRIVE • JEFFERSON CITY, MISSOURI 65109 • (573) 893-2446

VISION BENEFITS CLAIM

PART 1 – EMPLOYEE COMPLETES IN ALL CASES

EMPLOYEE'S NAME (PRINT) _____

PRESENT ADDRESS _____
(number and street) (city) (state) (zip)

EMPLOYEES SOCIAL SECURITY NO. ☐☐☐-☐☐-☐☐☐☐ BIRTHDATE _____ MARITAL STATUS _____
(M S D W)

IS ANY DEPENDENT UNDER THIS PLAN EMPLOYED ☐ YES ☐ NO

DO YOU OR YOUR COVERED DEPENDENTS HAVE OTHER GROUP HEALTH COVERAGE? ☐ YES ☐ NO
IF YES, PLEASE IDENTIFY: ☐ SPOUSE ☐ EMPLOYEE ☐ CHILD

NAME _____ DATE OF BIRTH _____

SOC. SEC. NO. OF PERSON WITH OTHER COVERAGE
☐☐☐-☐☐-☐☐☐☐

POLICY NO./ I.D. NO. _____

EFF. DATE _____

OTHER HEALTH COVERAGE

NAME _____

ADDRESS _____

_____

DOES OTHER GROUP COVERAGE LISTED ABOVE HAVE VISION BENEFITS? ☐ YES ☐ NO

I HEREBY AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. A COPY OR PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL. I ALSO CERTIFY THAT THE STATEMENTS MADE ARE TRUE, ACCURATE, AND COMPLETED TO THE BEST OF MY ABILITY; AND IF THE CLAIM IS FOR A DEPENDENT, THE DEPENDENT MEETS THE ELIGIBILITY REQUIREMENTS AS OUTLINED IN THE SUMMARY PLAN DESCRIPTION.

EMPLOYEE'S SIGNATURE MUST BE SIGNED _____ DATE THIS CLAIM FORM SIGNED _____

PART 2 – COMPLETE THIS SECTION IF CLAIM IS FOR YOUR DEPENDENT

DEPENDENT'S FULL NAME _____ FULL TIME STUDENT? ☐ YES ☐ NO RELATIONSHIP _____ DATE OF BIRTH _____ SINGLE ☐ MARRIED ☐

PART 3 – TO BE COMPLETED BY DOCTOR MAKING EXAMINATION

FULL NAME OF PATIENT _____ DATE OF EXAM _____ CHARGE FOR EXAM $ _____

DOCTOR'S NAME _____ GLASSES PRESCRIBED? ☐ YES ☐ NO

ADDRESS _____ **TAXPAYER I.D. NUMBER** _____
(Must be furnished under authority of law)

_____ TELEPHONE _____

DOCTOR'S SIGNATURE _____ DEGREE _____

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DOCTOR _____
EMPLOYEE SIGNATURE

PART 4 – TO BE COMPLETED BY SUPPLIER OF GLASSES

FULL NAME OF PATIENT _____

NAME OF OPTICAL ORGANIZATION _____

ADDRESS _____

_____

SUPPLIER'S SIGNATURE _____

TAXPAYER I.D. NUMBER _____ (Must be furnished under authority of law)

	AMOUNT CHARGED	✓ NEEDED BOX(ES) BOTH	LEFT	RIGHT
SINGLE VISION RX	$			
BI - FOCAL RX	$			
TRI - FOCAL RX	$			
CONTACTS	$			
LENTICULAR	$			
FRAMES	$			

PURCHASE DATE _____

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED SUPPLIER. _____
EMPLOYEE SIGNATURE