RETURN COMPLETED FORM TO:

IOWA LABORERS HEALTH & WELFARE FUND
150 First Ave. NE, Suite 450 - Cedar Rapids, IA 52401
Phone (319) 365-2810 - Fax (319) 365-1043

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?
☐ YES ☐ NO
IF YES, NAME _____
ADDRESS _____
CITY, STATE _____ ZIP _____

IS DEPENDENT ATTENDING SCHOOL?
☐ YES ☐ NO
IF YES, NAME _____
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,

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	☐	☐	$ _____	$ _____
SUB-NORMAL VISION AIDS	$ _____	LENSES-BIFOCAL	☐	☐	$ _____	$ _____
		LENSES-TRIFOCAL	☐	☐	$ _____	$ _____
		LENSES-LENTICULAR	☐	☐	$ _____	$ _____
		LENSES-CONTACT	☐	☐	$ _____	$ _____
				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	☐	☐	$ _____	$ _____
SUB-NORMAL VISION AIDS	$ _____	LENSES-BIFOCAL	☐	☐	$ _____	$ _____
		LENSES-TRIFOCAL	☐	☐	$ _____	$ _____
		LENSES-LENTICULAR	☐	☐	$ _____	$ _____
		LENSES-CONTACT	☐	☐	$ _____	$ _____
				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