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

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 or the reverse side of this form.

Employee's Signature _____

Date _____