

**ARCHITECTURAL IRON WORKERS' LOCAL NO. 63  
WELFARE FUND**

903 Commerce Drive, Suite 304 - Oakbrook, IL 60523  
(630) 472-0626

**VISION CARE BENEFITS**

**EMPLOYEE INFORMATION - REQUIRED for all claims**

Home Local Union No. \_\_\_\_\_

Name of Employee \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employee's Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_

Social Security No. \_\_\_\_\_ Occupation \_\_\_\_\_ Active  Retired

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ 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 \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_

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 registrar 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 \_\_\_\_\_ Date of Birth \_\_\_\_\_ Policy No. \_\_\_\_\_

C) Employer's street address \_\_\_\_\_

City, State \_\_\_\_\_ Zip \_\_\_\_\_

D) Policy Number \_\_\_\_\_ Certificate Number \_\_\_\_\_ Social Security Number \_\_\_\_\_ Phone Number ( \_\_\_ ) \_\_\_\_\_

NOTE: Attach a 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 \_\_\_\_\_

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:

					Each	Total
Frames	\$ _____	Lenses- Single Vision	ONE <input type="checkbox"/>	TWO <input type="checkbox"/>	\$ _____	_____
Sub-Normal Vision Aids	\$ _____	Lenses- Bifocal	ONE <input type="checkbox"/>	TWO <input type="checkbox"/>	\$ _____	_____
		Lenses- Trifocal	ONE <input type="checkbox"/>	TWO <input type="checkbox"/>	\$ _____	_____
		Lenses- Lenticular	ONE <input type="checkbox"/>	TWO <input type="checkbox"/>	\$ _____	_____
		Lenses- Contact	ONE <input type="checkbox"/>	TWO <input type="checkbox"/>	\$ _____	_____

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 lended for cosmetic purposes? \_\_\_\_\_ YES \_\_\_\_\_ NO
- b) Is this the frst pair following a cataract surgery \_\_\_\_\_ YES \_\_\_\_\_ NO
- 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:

					Each	Total
Frames	\$ _____	Lenses- Single Vision	ONE <input type="checkbox"/>	TWO <input type="checkbox"/>	\$ _____	_____
Sub-Normal Vision Aids	\$ _____	Lenses- Bifocal	ONE <input type="checkbox"/>	TWO <input type="checkbox"/>	\$ _____	_____
		Lenses- Trifocal	ONE <input type="checkbox"/>	TWO <input type="checkbox"/>	\$ _____	_____
		Lenses- Lenticular	ONE <input type="checkbox"/>	TWO <input type="checkbox"/>	\$ _____	_____
		Lenses- Contact	ONE <input type="checkbox"/>	TWO <input type="checkbox"/>	\$ _____	_____

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 \_\_\_\_\_