RETURN COMPLETED FORM TO:

SHEET METAL WORKERS' LOCAL 265, HEALTH & WELFARE FUND

205 Alexandra Way, Carol Stream, IL 60188-2080
Phone (630) 668-7260, 668-7291
www.smw265.org - email benefitspsmw265.org

VIS. - 2.0

VISION CARE BENEFITS

EMPLOYEE INFORMATION - REQUIRED for all claims

Name of Employee _____ Date of Birth _____

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 _____

Dependent's Social Security No. _____

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 Dependent have ANY other health insurance? ☐ YES ☐ NO IF YES please supply:

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:

				• EACH	TOTAL
FRAMES	$ _____	LENSES-SINGLE VISION	ONE ☐ TWO ☐	$ _____	$ _____
SUB-NORMAL VISION AIDS	$ _____	LENSES-BIFOCAL	ONE ☐ TWO ☐	$ _____	$ _____
		LENSES-TRIFOCAL	ONE ☐ TWO ☐	$ _____	$ _____
		LENSES-LENTICULAR	ONE ☐ TWO o	$ _____	$ _____
		LENSES- CONTACT	ONE a TWO ☐	$ _____	$ _____
				TOTAL $ _____	$ _____

7. If **contact lenses are being prescribed, please answer** the following:

a) Is this the first pair following cataract surgery? _____ YES _____ NO (If YES provide the date of surgery _____)

b) Would the visual acuity be corrected to 20/70 in better eye by use of conventional lenses? _____ YES _____ NO

c) 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 ☐ TWO o	$ _____	$ _____
SUB-NORMAL VISION AIDS	$ _____	LENSES-BIFOCAL	ONE ☐ TWO ☐	$ _____	$ _____
		LENSES-TRIFOCAL	ONE ☐ TWO ☐	$ _____	$ _____
		LENSES-LENTICULAR	ONE ☐ TWO ☐	$ _____	$ _____
		LENSES-CONTACT	ONE ☐ TWO ☐	$ _____	$ _____
				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