

ASBESTOS WORKERS LOCAL NO. 24 MEDICAL FUND VISION CARE CLAIM FORM

TELEPHONE
410-872-9500

7130 COLUMBIA GATEWAY DRIVE, SUITE A
COLUMBIA, MD 21046

THE BENEFIT ALLOWANCE WILL BE PAID TO THE EMPLOYEE ONLY

Print
Employee
Name _____

Soc.
Sec.
No. _____

Print
Address _____

Has Program
Been Used
Before? Yes No

Print
City _____

Print
State _____ Zip _____

Telephone
Number _____

Company
Employed By _____

Any other insurance coverage? Yes _____ No _____ If yes, name of insured _____

Name of insurance company and policy number _____

TO BE SIGNED BY EMPLOYEE:

The undersigned employee certifies that the above information is true and correct and the below services and materials were rendered and supplied as indicated. The undersigned also agrees to pay the doctor for the below services and materials. I hereby authorize the doctor to release the information requested on this form.

_____ Date

_____ Signature of Employee

Benefit Maximum:

\$175 per calendar year for professional fees, materials, lenses and frames.

Sunglasses not provided except in lieu of regular prescription glasses if eligible for same.

Broken glasses or frames not covered unless participant eligible for benefits again, and then in lieu of new glasses.

Fees and lenses available once each calendar year — **Frames only every other calendar year.**

TO BE COMPLETED BY DOCTOR (COMPLETE APPROPRIATE ITEMS BELOW)

EXAMINATION FEE: \$ _____ OPHTHALMIC MATERIALS: \$ _____ SINGLE or MULTI-VISION LENSES: \$ _____

PATIENT NAME _____ AGE _____ DATE OF EXAMINATION _____

_____ Address of Doctor

_____ Signature of Doctor

_____ City, State and Zip

_____ Type or Print Name and Fed. Tax I.D. No.