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
PLEASE ATTACH THE ITEMIZED BILL AND A COPY OF YOUR PAID RECEIPT

Print Employee Name _____

Social Security Number _____

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:

$250 per calendar year for professional fees, materials, lenses (including disposable contact 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.**
Pediatric vision expenses will be paid at 100%, subject to the limitations and restrictions reflected in the Summary Plan Description, but not limited to lenses, materials and eye exams.

TO BE COMPLETED BY DOCTOR (COMPLETE APPROPRIATE ITEMS BELOW)

EXAMINATION FEE: $_____ OPTHALMIC 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. _____