

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. 1.1



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? IF YES, NAME _____
☐ YES ☐ NO ADDRESS _____

CITY, STATE _____ ZIP _____

IS DEPENDENT ATTENDING SCHOOL? IF YES, NAME _____
☐ YES ☐ NO 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 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:

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

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 lenses for cosmetic purposes? _____ YES _____ NO

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

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:

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