



United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund

9801 West Higgins Road, Suite 500 ♦ Rosemont, IL 60018-4740 ♦ 847-384-7000 ♦ 800-621-5133

Customer Service FAX 847-384-0196 ♦ ufcwmidwest.org

Vision Claim Form — To be used for prescription eyeglasses, contact lenses and related eye exams

Instructions for Employee-Member

- A. You complete the front of the form and the top portion on the reverse.
B. Do not sign either "Authorization to Pay Benefits Directly" (on the reverse) until service is completed.
C. Have your eye doctor complete "To Be Completed by the Doctor" (or substitute a similar form) and return the claim form to you.
D. If the examining eye doctor is not dispensing your frames/lenses, have the optical company that dispenses your frames/lenses complete "To Be Completed by the Optical Company" or attach their invoice and return the claim form to you.
E. If you wish payment to be made directly to the doctor and/or optical company, sign the appropriate "Authorization to Pay Benefits Directly" on the reverse. Do not sign either authorization if you wish payment to be made to you.
F. Attach any related bills or receipts and forward the claim form to the Benefits Fund Office.

Employee-Member and Claim Information—Receipt of this claim form does not guarantee payment of benefits

1. YOUR FULL NAME (EMPLOYEE-MEMBER) MAIDEN NAME UFCW ID# or SOCIAL SECURITY NUMBER
2. STREET ADDRESS CITY STATE ZIP CHECK IF NEW ADDRESS
3. DAYTIME AREA CODE/PHONE NUMBER GENDER DATE OF BIRTH MARRITAL STATUS DATE MARRIED
4. NAME AND ADDRESS OF ANY NON-UFCW COMPANY WHERE YOU ARE ALSO EMPLOYED
5. FULL NAME OF PATIENT RELATIONSHIP TO EMPLOYEE-MEMBER

Spouse Information—Complete for all Claims

6. FULL NAME OF SPOUSE DATE OF BIRTH SOCIAL SECURITY NUMBER
7. IF DIFFERENT FROM EMPLOYEE-MEMBER, STREET ADDRESS CITY STATE ZIP DAYTIME AREA CODE/PHONE NUMBER
8. NAME AND ADDRESS OF SPOUSE'S EMPLOYER (OR FORMER EMPLOYER) AREA CODE/PHONE NUMBER

Dependent Child Information—Complete only if Claim is for a Dependent Child

9. DEPENDENT'S FULL NAME—FIRST AND LAST NAME RELATIONSHIP DATE OF BIRTH SOCIAL SECURITY NUMBER
10. IF DIFFERENT FROM EMPLOYEE-MEMBER, STREET ADDRESS CITY STATE ZIP DAYTIME AREA CODE/PHONE NUMBER
11. EMPLOYER NAME AND ADDRESS CHECK IF NOT EMPLOYED

Other Insurance Information—Complete for all Claims

12. IS PATIENT COVERED UNDER ANY OTHER GROUP HEALTH INSURANCE OR BENEFIT PLAN, SUCH AS, GROUP BLUE CROSS, A SCHOOL PLAN, A GOVERNMENT PLAN, AN AUTO INSURANCE PLAN, ETC.? IF "YES," PLEASE PROVIDE THE INFORMATION REQUESTED BELOW.
13. POLICYHOLDER'S FULL NAME—FIRST AND LAST NAME RELATIONSHIP TO EMPLOYEE-MEMBER DAYTIME AREA CODE/PHONE NUMBER
14. NAME OF PLAN OR COMPANY POLICY NUMBER
15. ADDRESS CITY STATE ZIP AREA CODE/PHONE NUMBER

Signatures—Employee-Member and Patient (or Parent, if patient is a minor) must sign or benefits cannot be paid

I certify that the above answers and statements, including any accompanying statements, are true and complete to the best of my knowledge and belief. I authorize any physician, medical examiner or practitioner, coroner, hospital, Veterans Administration Hospital, clinic, other medical or medical-related facility, insurance or reinsuring company, consumer reporting agency, employer, school, or group policyholder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the patient for whom claim is made, to give to UFCW Midwest Health Benefits Fund or its legal representative, any and all such information. A photocopy of this authorization shall be as valid as the original.

Date Signature Employee-Member sign here
Date Signature Patient (or Parent) sign here

EMPLOYEE-MEMBER NAME	UFCW ID# or SOCIAL SECURITY NUMBER	PATIENT NAME
----------------------	------------------------------------	--------------

Assignment of Benefits—Sign only if benefits to be paid directly to service provider

Do not sign either "Authorization to Pay Benefits" below until all services are completed and you have received your frames and/or lenses. Once your signed authorization has been received at the Benefits Fund Office, we will pay your Vision Benefit, if any, directly to the doctor and/or optical company.

AUTHORIZATION TO PAY BENEFITS DIRECTLY TO DOCTOR: I hereby authorize payment directly to the undersigned doctor for the Vision Benefit, if any, otherwise payable to me for the services as described below.



SIGNED (EMPLOYEE-MEMBER)

_____ DATE _____

AUTHORIZATION TO PAY BENEFITS DIRECTLY TO OPTICAL COMPANY: I hereby authorize payment directly to the optical company identified below for the Vision Benefits, if any, otherwise payable to me for the services as described below.



SIGNED (EMPLOYEE-MEMBER)

_____ DATE _____

To Be Completed by the Doctor—Use this form or attach a similar form of your own

DOCTOR'S NAME (PRINT)		DEGREE	
STREET ADDRESS			
CITY	STATE	ZIP CODE	
AREA CODE/PHONE NUMBER		LICENSE NUMBER	
TAX ID # OR SOCIAL SECURITY NUMBER		PATIENT NAME	

PRESCRIPTION NECESSARY FOR LENSES AND/OR FRAMES

	SPHERE	CYLINDER	AXIS	PRISM
RIGHT EYE				
LEFT EYE				

I certify that I have performed the services indicated hereon for the patient named above.
 Date _____ Doctor Signature _____

<u>SERVICE</u>	<u>CHARGE</u>
Examination and Refraction:	
<input type="checkbox"/> Optometric <input type="checkbox"/> Ophthalmologic	
Diagnosis _____	
Date of Exam _____	\$ _____
Lenses:	
<input type="checkbox"/> Single Vision <input type="checkbox"/> Lenticular	
<input type="checkbox"/> Bi-Focal <input type="checkbox"/> Tri-Focal <input type="checkbox"/> Contacts	\$ _____
Frames:	
Name _____	
Material _____	
Manufacturer _____	\$ _____
Date Frames and/or Lenses Delivered _____	
Total Charges	\$ _____
Less Amount Paid	\$ _____
Balance Due	\$ _____

To Be Completed by Optical Company Dispensing Frames and/or Lenses—Use this form or attach a similar form of your own

PRESCRIPTION				
	SPHERE	CYLINDER	AXIS	PRISM
RIGHT EYE				
LEFT EYE				
OPTICAL COMPANY NAME (PRINT)				
STREET ADDRESS				
CITY	STATE	ZIP CODE		
AREA CODE/PHONE NUMBER		TAX ID # OR SOCIAL SECURITY NUMBER		
SIGNATURE OF AUTHORIZED PERSONNEL				

<u>SERVICE</u>	<u>CHARGE</u>
Lenses:	
<input type="checkbox"/> Single Vision <input type="checkbox"/> Lenticular	
<input type="checkbox"/> Bi-Focal <input type="checkbox"/> Tri-Focal <input type="checkbox"/> Contacts	\$ _____
Frames:	
Name _____	
Material _____	
Manufacturer _____	\$ _____
Date Frames and/or Lenses Delivered _____	
Total Charges	\$ _____
Less Amount Paid	\$ _____
Balance Due	\$ _____