United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund
2625 Butterfield Rd, Suite 208E, Oak Brook, IL 60523
800-621-5133 * Fax 847-384-0197 * www.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 PHONE NUMBER | ☐ MALE ☐ FEMALE | DATE OF BIRTH | ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ MARRIED ☐ SEPARATED | 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 PHONE NUMBER

8. NAME AND ADDRESS OF SPOUSE'S EMPLOYER (OR FORMER EMPLOYER) | 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 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. ☐ YES ☐ NO

13. POLICYHOLDER'S FULL NAME - FIRST AND LAST NAME | RELATIONSHIP TO EMPLOYEE-MEMBER | DAYTIME PHONE NUMBER

14. NAME OF PLAN OR COMPANY | POLICY NUMBER

15. ADDRESS | CITY | STATE | ZIP | 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-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 valid as the original.

Date ____________ Signature ______________________________ ☞ Employee-Member sign here

Date ____________ Signature ______________________________ ☞ Patient (or Parent) sign here

(Continued on Reverse)

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 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
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 ______________________

SERVICE **CHARGE**

Examination and Refraction:

☐ Optometric ☐ Ophthalmologic

Diagnosis ____________________________

____

Date of Exam ____________________________ $________

Lenses:

☐ Single Vision ☐ Lenticular

☐ Bi-Focal ☐ Tri-Focal ☐ 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
PHONE NUMBER	TAX ID# OR SOCIAL SECURITY NUMBER	
SIGNATURE OF AUTHORIZED PERSONNEL		

SERVICE **CHARGE**

Lenses:

☐ Single Vision ☐ Lenticular

☐ Bi-Focal ☐ Tri-Focal ☐ Contacts $________

Frames:

Name ____________________________

Material ____________________________

Manufacturer ____________________________ $________

Date Frames and/or Lenses Delivered ______________________

Total Charges $________

Less Amount Paid $________

Balance Due $________