



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

1300 Higgins Road, Suite 300 ♦ Park Ridge, IL 60068-5713 ♦ 847-384-7000 ♦ 800-621-5133

CLAIMS OFFICE FAX 847-384-0196 ♦ TDD 847-384-0199 ♦ 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 a 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 <input checked="" type="checkbox"/> IF NEW ADDRESS <input type="checkbox"/>				
3. DAYTIME AREA CODE/PHONE NUMBER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	<input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED
<input type="checkbox"/> WIDOWED				
DATE MARRIED				
4. NAME AND ADDRESS OF ANY NON-UFCW COMPANY WHERE YOU ARE ALSO EMPLOYED				

Spouse (or other Parent if claim is for Dependent Child) Information—Complete for all Claims

5. FULL NAME OF SPOUSE OR PARENT		RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER
6. IF DIFFERENT FROM EMPLOYEE-MEMBER, STREET ADDRESS		CITY	STATE	ZIP
DAYTIME AREA CODE/PHONE NUMBER				
7. NAME AND ADDRESS OF SPOUSE OR PARENT'S EMPLOYER (OR FORMER EMPLOYER)				AREA CODE/PHONE NUMBER
8. IS PATIENT COVERED UNDER ANY OTHER GROUP HEALTH INSURANCE OR BENEFIT PLAN WHICH MAY ALSO PAY ANY MEDICAL EXPENSES ON THIS CLAIM (SUCH AS, GROUP BLUE CROSS, A SCHOOL PLAN, A GOVERNMENT PLAN, AUTO INSURANCE PLAN, ETC.)? IF "YES," PROVIDE THE INFORMATION REQUESTED BELOW REGARDING THE OTHER PLAN. <input type="checkbox"/> YES <input type="checkbox"/> NO				
9. NAME OF PLAN OR COMPANY				POLICY NUMBER
10. ADDRESS		CITY	STATE	ZIP
AREA CODE/PHONE NUMBER				

Dependent Information—Complete Only if Claim is for a Dependent

11. DEPENDENT'S FULL NAME—FIRST AND LAST NAME		RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER
12. IF DIFFERENT FROM EMPLOYEE-MEMBER, STREET ADDRESS		CITY	STATE	ZIP
13. EMPLOYER NAME AND ADDRESS				CHECK <input checked="" type="checkbox"/> IF NEW ADDRESS <input type="checkbox"/>
14. IF CHILD, IS CHILD MARRIED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF CHILD OVER 18 YEARS, IS CHILD A FULL-TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES," SUBMIT EVIDENCE OF STUDENT STATUS DURING THE SEMESTER WHEN EXPENSE WAS INCURRED (E.G., STUDENT ID, LETTER FROM SCHOOL)		

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 United Food and Commercial Workers Unions and Employers 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
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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 _____

SERVICE	CHARGE
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 _____

SERVICE	CHARGE
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	\$ _____