

**VISION CLAIM FORM**

The Plan will pay a benefit of \$600.00 per FAMILY beginning January 1 and ending December 31. Claim forms are available at the Fund Office, Union Hall, or our Web site: [www.bmgweb.com/441](http://www.bmgweb.com/441). A COPY OF THE LENS PRESCRIPTION & ITEMIZED STATEMENT WITH THE PATIENT NAME LISTED ARE REQUIRED WITH THE CLAIM FORM. The \$600.00 per family is applicable to “Dates of Service” within a calendar year. The Fund will not pay on any claim submitted later than one year and 90 days after the service date.

**THIS SECTION TO BE COMPLETED BY UNION MEMBER &/OR SPOUSE**

MEMBER’S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ SOC. SEC. # XXX-XX-\_\_\_\_\_

Street \_\_\_\_\_  
\_\_\_\_\_ HOME PHONE # \_\_\_\_\_  
City State Zip

EMPLOYER \_\_\_\_\_

NAME OF SPOUSE \_\_\_\_\_ DAYTIME # \_\_\_\_\_ EMPLOYER \_\_\_\_\_

**DOES THE PATIENT HAVE OPTICAL OR EYE GLASS COVERAGE FROM ANY OTHER SOURCE? YES \_\_\_ NO \_\_\_**  
**(IF “YES”, PRIMARY NAME ON INSURANCE: \_\_\_\_\_, INS. PROVIDER: \_\_\_\_\_)**  
**You must also attach a copy of the Summary (EOB) from the other Insurance Provider. Claim will not be paid out without this documentation).**

**CLAIM FOR \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_**  
Name

By signing below, I certify that the above answers, including and accompanying statement, are true and complete. I authorize any physician, hospital or insurance company to disclose any acknowledge or information concerning this or other claims to the Plumbing and Pipefitting Industry Health and Welfare Fund of Kansas, or its’ representatives. I expressly waive on behalf of myself and of any person who shall have interest in the benefits, all provisions of the law to the contrary. A photocopy of this authorization shall be as valid as the original.

**SIGNED \_\_\_\_\_ DATE SIGNED \_\_\_\_\_**

**PRINT NAME \_\_\_\_\_ RELATION TO MEMBER \_\_\_\_\_**

**STOP!!! FOR HEALTH & WELFARE FUND OFFICE USE ONLY**

PREV. PD \$ \_\_\_\_\_ FOR YEAR \_\_\_\_\_  
AMOUNT OVER \$600.00 MAX? \_\_\_\_\_  
DENIAL LETTER COMPLETED BY \_\_\_\_\_

YEAR \_\_\_\_\_  
PD \$ \_\_\_\_\_

**PROVIDER OF EYE EXAM? \_\_\_\_\_ DATE \_\_\_\_\_ FEE \$ \_\_\_\_\_**

**PROVIDER OF LENSES? \_\_\_\_\_ DATE \_\_\_\_\_ FEE \$ \_\_\_\_\_**

**PROVIDER OF FRAMES? \_\_\_\_\_ DATE \_\_\_\_\_ FEE \$ \_\_\_\_\_**

**PROVIDER OF CONTACTS? \_\_\_\_\_ DATE \_\_\_\_\_ FEE \$ \_\_\_\_\_**

\$ \_\_\_\_\_

**OTHER INSURANCE OR OTHER DISCOUNTS ..... (\$ \_\_\_\_\_)**

**TOTAL ..... \$ \_\_\_\_\_**