Sheet Metal Workers Local 22 Welfare Fund

OPTICAL BENEFIT CLAIM FORM

14

MEMBER AND PATIENT INFORMATION

1. Patient's Name _____
2. Patient's Address _____
   _____
3. Patient's Sex (Circle) Male Female
4. Patient's Date of Birth ____/____/____
5. Member's Name _____
6. Member's Address _____
   Telephone # (_____)_____-_____
7. Social Security Number _____
8. Patient's Relationship to Member (Circle) Self Spouse Child Other

ATTACH ALL COPIES OF BILL SHOWING COST OF EYEGLASSES.
THE COST OF THE LENSES AND FRAMES SHOULD BE LISTED SEPARATELY.

Dear Member:

All information requested on this claim form must be completes in full. You must attach a copy of all bills including doctor if you had an eye exam and a copy of your bill for your eyeglasses. These bills should list the cost of examination, lenses, and frames separately.

Remember that you will be reimbursed for an eye examination, including frames with single, bifocal, trifocal, or progressive lenses **once every 12 months**.

You will receive payment based on the following schedule:

Eye Examination by Ophthalmologist (M.D.)	up to $50
Eye Examination by Optometrist (O.D.)	up to $25
Single Vision Lenses	up to $50 per pair
Bi, Tri and Progressive Lenses	up to $70 per pair
Frames	up to $40 per pair
Safety Glasses	up to $200 per pair

Mail the completed form and copies of bills to:

SHEET METAL WORKERS LOCAL 22 WELFARE FUND
106 SOUTH AVENUE WEST
CRANFORD, NJ 07016

DO NOT FILL OUT. FOR FUNDS OFFICE ONLY

	COST	**AMOUNT TO BE REIMBURSED**
Eye Examination: M.D. or O.D. (circle)	_____	_____
Lenses : Single, Bi, Tri, Progressive (circle)	_____	_____
Frames :	_____	_____
TOTAL :	_____	_____

Check Number : _____

Date Issued : _____