SHEET METAL WORKERS LOCAL 22
WELFARE FUND

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
9. Are you or any of your family members covered through any other welfare fund or employer paid group health plan which provides hospital, medical or similar services to those provided by this Fund? ☐ Yes ☐ No
   If yes, give name and address of organization providing services:
   _____
   _____
   _____
10. Are any of the vision care charges in connection with an illness or accident which is due in any way to your or your dependent's occupation? ☐ Yes ☐ No
    If yes, give complete details. (Attach separate statement in explanation.)

EYE EXAMINATION (TO BE COMPLETED BY OPHTHALMOLOGIST OR OPTOMETRIST)

1. Doctor's Name (Type or Print) _____
2. Ophthalmologist (M.D.) or Optometrist (O.D.) (Circle)
3. Doctor's Address _____
   Telephone: _____
4. Patient's Name _____
5. Date Eye Examination Performed ___/___/___
6. Was the service performed in connection with an illness or injury related to the patient's employment?
   ☐ Yes ☐ No
7. Doctor's Signature _____ Taxpayer's I.D. No. _____
   Date _____

ATTACH COPY OF BILL SHOWING COST OF EYE EXAMINATION

EYEGLASSES (TO BE COMPLETED BY OPTOMETRIST OR OPTICIAN)

1. Name of Eyeglass Supplier _____
   (Optometrist or Optician)
2. Supplier's Address _____
   Telephone: _____
3. Name of Patient _____
4. Type of Lenses (Circle) Single Vision Bi-Focal Tri-Focal
5. Was the service and/or materials in connection with the fitting of sunglasses? ☐ Yes ☐ No
6. Supplier's Signature _____ Date _____

ATTACH COPY OF BILL SHOWING COST OF EYEGLASSES.
THE COSTS OF THE LENSES AND FRAMES SHOULD BE LISTED SEPARATELY.
IMPORTANT: SEE OTHER SIDE FOR INSTRUCTIONS

INSTRUCTIONS FOR OPTICAL BENEFIT CLAIM FORM

Dear Member:

All information requested on this claim form must be completed in full. You must attach a copy of the doctor's bill if you have had an eye examination and a copy of the bill for your eyeglasses. These bills should list the costs of examination, lenses and frames separately.

Remember that you will be reimbursed for an eye examination and single-vision lenses once every twelve months, and for frames, bi-focal or tri-focal lenses once every twelve months. You will receive payment based on the following schedule.

Procedure	Payment
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-focal lenses	Up to $70 per pair
Tri-focal lenses	Up to $70 per pair
Frames	Up to $40 per pair

Mail the completed form and copies of the bills to:

SHEET METAL WORKERS LOCAL 22 WELFARE FUND
106 SOUTH AVENUE W.
CRANFORD, NEW JERSEY 07016

FOR FUND OFFICE ONLY

	Cost		Amount Paid
Eye Examination	_____	M.D. or O.D. (Circle)	_____
Lenses	_____	Single, Bi-Fical, Tri-Focal (Circle)	_____
Frames	_____		_____
Total	_____		_____

Claim No. _____

Check No. _____

Date Issued _____