MECHANICS' LOCAL 701 WELFARE FUND

500 W. Plainfield Road • Countryside, IL 60525
TEL (708) 482-0110 • FAX (708) 482-9140

☐ Please check if your address has changed since your last claim

INSTRUCTIONS: This Claim Form is to furnish the information needed to service your VISION Expense Claim.

PLEASE ANSWER ALL QUESTIONS FULLY AND ATTACH ALL APPROPRIATE ITEMIZED BILLS AND PAID RECEIPTS

PART A - TO BE COMPLETED BY THE EMPLOYEE-MEMBER CLAIMING VISION BENEFITS FOR SELF OR DEPENDENT			
YOUR FULL NAME (EMPLOYEE-MEMBER)	☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED	☐ MALE ☐ FEMALE	ID # ____ DATE OF BIRTH ___/___/___
YOUR HOME ADDRESS (NO. & STREET) (CITY) (STATE) (ZIP CODE)			

COMPLETE THIS SECTION ONLY IF CLAIM IS FOR DEPENDENT			
DEPENDENT'S LAST NAME	FIRST NAME	RELATIONSHIP	DEPENDENT'S DATE OF BIRTH / /
ADDRESS (IF DIFFERENT FROM MEMBER)			IF CHILD, IS CHILD MARRIED? ☐ YES ☐ NO
IF CHILD, IS CHILD WORKING? ☐ YES ☐ NO	NAME, ADDRESS AND PHONE NUMBER OF EMPLOYER		

INFORMATION ABOUT MEMBER'S SPOUSE OR OTHER PARENT OF DEPENDENT CHILD (THIS BOX MUST BE COMPLETED FOR ALL CLAIMS)		
NAME OF SPOUSE OR PARENT (other than Member)		IS SPOUSE OR PARENT EMPLOYED? ☐ YES ☐ NO
NAME OF SPOUSE'S OR PARENT'S EMPLOYER (other than Member)	SPOUSE'S OR PARENT'S DATE OF BIRTH	UNION AFFILIATION
ADDRESS OF SPOUSE'S OR PARENT'S EMPLOYER (other than Member)	TELEPHONE NUMBER	EMPLOYMENT DATE

ARE YOU OR YOUR DEPENDENT INSURED OR COVERED UNDER ANY OTHER GROUP INSURANCE OR WELFARE PLAN THROUGH ANY EMPLOYER OR LABOR ORGANIZATION?
☐ YES ☐ NO IF YES, GIVE NAME AND ADDRESS, AND POLICY NUMBER, OR INSURANCE COMPANY OR PLAN OFFICE PROVIDING BENEFITS.

NAME OF COMPANY	POLICY HOLDER NAME
ADDRESS	POLICY NO. / ID NO.
	PHONE NO.

LIST ALL PERSONS COVERED BY THE OTHER PLAN

____

____

____

____

____

THIS PLAN COVERS
(CHECK ALL THAT APPLY)

❑ MEDICAL ❑ DENTAL ❑ VISION

BOTH EMPLOYEE AND SPOUSE MUST SIGN IN ALL CASES TO RECEIVE PAYMENT

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 practition, coroner, hospital, veterans administration Hospital, clinic, other medical or medically-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 insured of the family members for which claim is made, to give to AUTOMOBILE MECHANICS LOCAL NO. 701 UNION AND INDUSTRY WELFARE FUND or its legal respresentative, any and all such information a photocopy of this authorization shall be as valid as the original.

Date claim signed ____________ Signature ____________ Employee sign here

Phone ( ) ____________ Signature ____________ Spouse sign here

DOCTOR'S CLAIM REPORT
PLEASE ANSWER ALL QUESTIONS & ITEMIZE ALL EXPENSES ON #8

PATIENT'S NAME ______________________________ DATE OF BIRTH __________

ADDRESS ____
(Street) (City) (State) (Zip Code)

1. **Diagnosis** ____

____

2. **Is this examination the result of an injury or sickness arising out of patient's employment?**
   Yes ☐ **No** ☐

3. **Is this examination required as a condition of employment?** **Yes** ☐ **No** ☐
   If yes, please explain ____

4. **Is this the initial placement of lens or frames?** **Yes** ☐ **No** ☐
   If no, what was the date of the prior placement of lens __________ **frames** __________

5. **Are the lens or frames for sunglasses?** **Yes** ☐ **No** ☐

6. **Is any of the reported expense for special procedures such as orthoptic and visual training?** **Yes** ☐ **No** ☐
   If yes, please explain ____

____

7. **Examination Date** __________________ **Charge $**__________
8. **Single Vision RX** **Left $**______ **Right $**______ Total $__________
   Bi-focal RX **Left $**______ **Right $**______ Total $__________
   Tri-focal RX **Left $**______ **Right $**______ Total $__________
   Contacts **Left $**______ **Right $**______ Total $__________
   Frames $__________ Total $__________
   Date Lens or Frames Dispensed __________ Total Cost $__________

NOTE: For reimbursement you must attach proof of payment to this fully completed vision form. Proof of payment could be a copy of your cancelled check, register receipt, payment receipt from physician or a credit card receipt. The fund office will always make payments directly to the authorized member.

------------------ DOCTOR, PLEASE SIGN HERE ------------------

Date ____________________ **Signed X** ______________________________

Name ____________________ **Tax Identification Number** __________ **Degree** ______
(Print or Type) **Required by Law**

Address ____
(Street) **(City)** **(State)** **(Zip Code)**

Phone ____________________