

SHEET METAL WORKERS LOCAL NO. 110  
WELFARE TRUST FUND

RETURN THIS FORM TO:

American Benefits Corporation  
3150 Rt 60  
Ona, WV 25545

**VISION CARE CLAIM FORM**

TO BE COMPLETED BY EMPLOYEE				
NAME OF EMPLOYEE		<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	SEX AGE	PHONE NO.
ADDRESS OF EMPLOYEE	NUMBER AND STREET	CITY	STATE	ZIP CODE
ARE GROUP HEALTH INSURANCE BENEFITS PAYABLE FROM ANY OTHER SOURCE FOR THE EXPENSES SUBMITTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF "YES" (A) INSURING ORGANIZATION (B) EMPLOYER		

IF CLAIM IS FOR DEPENDENT ANSWER THE FOLLOWING QUESTIONS

NAME OF DEPENDENT	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	SEX AGE	RELATIONSHIP
ADDRESS OF DEPENDENT	EMPLOYER OF DEPENDENT		

**AUTHORIZATION**

EMPLOYER	I AUTHORIZE RELEASE TO SHEET METAL WORKERS LOCAL NO. 110 FUND OF ANY INFORMATION REQUIRED TO PROCESS MY CLAIM. A PHOTOCOPY OF THIS AUTHORIZATION MAY BE HONORED.
DATE	EMPLOYEE'S SIGNATURE I AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDER OF SERVICE.
	EMPLOYEE'S SIGNATURE

**TO BE COMPLETED BY DOCTOR**

PATIENT'S NAME	PATIENT'S ADDRESS
WAS PRESCRIPTION WRITTEN? <input type="checkbox"/> YES <input type="checkbox"/> NO	INITIAL GLASSES OR REPLACEMENT?
IF REPLACEMENT, INDICATE CHANGE IN DIOPTRER AND DEGREE OF AXIS FROM PRIOR PRESCRIPTION:	
ARE LENSES FOR SUNGLASSES? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF PRIOR PRESCRIPTION

**INDICATE CHARGES FOR SERVICES & MATERIALS:**

EXAMINATION: DATE	FEE CHARGED: \$ _____
LENSES FURNISHED: DATE SHOW TYPE BY CHECK MARK.	FEE CHARGED: \$ _____
SINGLE VISION _____ BIFOCAL _____	DATE OF DELIVERY: _____
TRIFOCAL _____ LENTICULAR _____	
CONTACTS _____	
FRAMES: DATE	FEE CHARGED: \$ _____
TOTAL COST TO PATIENT: FEE CHARGED: \$ _____	
DATE: STATE LICENSE REG. NO.	TAX I.D. NO.
DOCTOR'S SIGNATURE	DOCTOR'S ADDRESS