

JOINT WELFARE FUND — Local 164
VISION BENEFITS CLAIM FORM

Please return completed form to:
FABIAN & BYRN LLC — 204 Eagle Rock Avenue, Second Floor, Roseland, NJ 07068
Tel: (973) 228-4200 • Fax: (973) 228-4240

TO BE COMPLETED BY MEMBER

Note to Member: A receipt for services must be enclosed.

1. Member's Name _____
2. Address _____
3. S. S. No. _____ Telephone No. _____
4. Patient's Name _____ Relationship _____ Date of Birth _____
5. Date _____ Member's Signature _____

Are you or any of your family members covered through any other welfare 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

Are any of the vision care charges in connection with a sickness or accident which is due in any way to you or your dependent (s) occupation?

If "YES" furnish complete details. (Attach separate statement in explanation.)

- YES NO

TO BE COMPLETED BY OPHTHALMOLOGIST, OPTOMETRIST OR OPTICIAN

1. Date of Optical Examination _____
2. Service Rendered and Fee
- Eye Examination \$ _____
- Lenses \$ _____
- Frames \$ _____
- Other \$ _____
3. Total charge for services rendered \$ _____

Describe in detail on bill presented to member the services rendered and type of glasses purchased.

IN ORDER TO PROPERLY EVALUATE THE EXPENSES DESCRIBED ABOVE PLEASE ANSWER THE FOLLOWING QUESTIONS:

WERE THE SERVICES AND / OR MATERIALS IN CONNECTION WITH:

- A. SICKNESS OR ACCIDENT ARISING OUT OF THE PATIENT'S EMPLOYMENT YES NO
- B. FITTING OF SUNGLASSES YES NO

Please Print

Name _____ Office Address _____

Telephone No. _____ Signature _____

Tax I.D. No. _____

