

RETURN  
COMPLETED  
FORM TO:

**IOWA LABORERS HEALTH & WELFARE FUND**  
150 First Ave. NE, Suite 450 - Cedar Rapids, IA 52401  
Phone (319) 365-2810 - Fax (319) 365-1043

VIS. 1.1



**VISION CARE BENEFITS**

**EMPLOYEE INFORMATION - REQUIRED for all claims**

Home Local Union No. \_\_\_\_\_

Name of Employee \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Last) (First) (Middle)

Employee's Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_

Social Security No. \_\_\_\_\_ Occupation \_\_\_\_\_ Active  Retired

Street Address \_\_\_\_\_

City, State \_\_\_\_\_ Zip \_\_\_\_\_ Phone number ( ) \_\_\_\_\_

**DEPENDENT INFORMATION - If Claim is For Your Dependent**

Name of Dependent \_\_\_\_\_

Relationship to Employee \_\_\_\_\_ Date of Birth \_\_\_\_\_

Dependent's Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_

IS DEPENDENT EMPLOYED? IF YES, NAME \_\_\_\_\_  
 YES  NO ADDRESS \_\_\_\_\_

CITY, STATE \_\_\_\_\_ ZIP \_\_\_\_\_

IS DEPENDENT ATTENDING SCHOOL? IF YES, NAME \_\_\_\_\_  
 YES  NO ADDRESS \_\_\_\_\_

CITY, STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**NOTE:** Attach letter from the school with certified transcript stating that Dependent is a full-time student.

**OTHER INSURANCE INFORMATION**

Do you or your Dependents have ANY other health insurance?  YES  NO IF YES,

A) Name of the person insured \_\_\_\_\_ Relationship to Employee \_\_\_\_\_

B) Insured person's employer \_\_\_\_\_

C) Employer's street address \_\_\_\_\_

City, State \_\_\_\_\_ Zip \_\_\_\_\_

D) Policy number \_\_\_\_\_ Certificate number \_\_\_\_\_ Social Security number \_\_\_\_\_ Phone number ( ) \_\_\_\_\_

**NOTE:** Attach copy of payment worksheet or denial from other insurance or Medicare.

**AUTHORIZATION**

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release, when requested by the Trustees or their representative, of any facts concerning the treatment of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

**ASSIGNMENT**

I hereby authorize payment of Vision Care Benefits directly to the provider(s) of services and materials described on the reverse side of this form.

Employee's Signature \_\_\_\_\_

Date \_\_\_\_\_

**TO BE COMPLETED BY OPHTHALMOLOGIST OR OPTOMETRIST**

PATIENT'S NAME \_\_\_\_\_ AGE \_\_\_\_\_

1. Indicate the nature of eye examination: \_\_\_\_\_ Initial Exam \_\_\_\_\_ Continuing Care  
 \_\_\_\_\_ Complete examination, including eye refraction. Date of Exam \_\_\_\_\_ Fee \$ \_\_\_\_\_  
 \_\_\_\_\_ Complete examination, excluding eye refraction. Date of Exam \_\_\_\_\_ Fee \$ \_\_\_\_\_

2. Has patient previously had glasses? \_\_\_\_\_ YES (Give Date \_\_\_\_\_ ) \_\_\_\_\_ NO

3. Does patient require a prescription change at this time? \_\_\_\_\_ YES \_\_\_\_\_ NO

4. Were tinted lenses prescribed? \_\_\_\_\_ YES \_\_\_\_\_ NO

5. Are these lenses to be used primarily as sunglasses? \_\_\_\_\_ YES \_\_\_\_\_ NO

6. Materials prescribed or provided:

|                        |          |                      | ONE                      | TWO                      | <b>EACH</b> | <b>TOTAL</b> |
|------------------------|----------|----------------------|--------------------------|--------------------------|-------------|--------------|
| FRAMES                 | \$ _____ | LENSES-SINGLE VISION | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____    | \$ _____     |
|                        |          |                      | <input type="checkbox"/> | <input type="checkbox"/> |             |              |
| SUB-NORMAL VISION AIDS | \$ _____ | LENSES-BIFOCAL       | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____    | \$ _____     |
|                        |          |                      | <input type="checkbox"/> | <input type="checkbox"/> |             |              |
|                        |          | LENSES-TRIFOCAL      | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____    | \$ _____     |
|                        |          |                      | <input type="checkbox"/> | <input type="checkbox"/> |             |              |
|                        |          | LENSES-LENTICULAR    | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____    | \$ _____     |
|                        |          |                      | <input type="checkbox"/> | <input type="checkbox"/> |             |              |
|                        |          | LENSES-CONTACT       | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____    | \$ _____     |
|                        |          |                      | <input type="checkbox"/> | <input type="checkbox"/> |             |              |
|                        |          | <b>TOTAL</b>         |                          |                          | \$ _____    | \$ _____     |

7. Are frames or lenses being replaced as a result of breakage, or loss? (Circle One) Frames: YES NO Lenses: YES NO

8. If contact lenses are being prescribed, please answer the following:

- a) Are these lenses for cosmetic purposes? \_\_\_\_\_ YES \_\_\_\_\_ NO  
 b) Is this the first pair following cataract surgery? \_\_\_\_\_ YES \_\_\_\_\_ NO (If YES provide the date of surgery \_\_\_\_\_)  
 c) Would the visual acuity be corrected to 20/70 in better eye by use of conventional lenses? \_\_\_\_\_ YES \_\_\_\_\_ NO  
 d) Will the use of contact lenses correct the visual acuity to 20/70 or better? \_\_\_\_\_ YES \_\_\_\_\_ NO

DOCTOR'S SIGNATURE \_\_\_\_\_ DEGREE \_\_\_\_\_ DATE \_\_\_\_\_  
 PRINT OR TYPE DOCTOR'S NAME \_\_\_\_\_ TAX I.D. NO. \_\_\_\_\_ TELEPHONE NO. \_\_\_\_\_  
 STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**TO BE COMPLETED BY OPTICIAN OR LAB**

1. Materials prescribed or provided:

|                        |          |                      | ONE                      | TWO                      | <b>EACH</b> | <b>TOTAL</b> |
|------------------------|----------|----------------------|--------------------------|--------------------------|-------------|--------------|
| FRAMES                 | \$ _____ | LENSES-SINGLE VISION | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____    | \$ _____     |
|                        |          |                      | <input type="checkbox"/> | <input type="checkbox"/> |             |              |
| SUB-NORMAL VISION AIDS | \$ _____ | LENSES-BIFOCAL       | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____    | \$ _____     |
|                        |          |                      | <input type="checkbox"/> | <input type="checkbox"/> |             |              |
|                        |          | LENSES-TRIFOCAL      | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____    | \$ _____     |
|                        |          |                      | <input type="checkbox"/> | <input type="checkbox"/> |             |              |
|                        |          | LENSES-LENTICULAR    | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____    | \$ _____     |
|                        |          |                      | <input type="checkbox"/> | <input type="checkbox"/> |             |              |
|                        |          | LENSES-CONTACT       | <input type="checkbox"/> | <input type="checkbox"/> | \$ _____    | \$ _____     |
|                        |          |                      | <input type="checkbox"/> | <input type="checkbox"/> |             |              |
|                        |          | <b>TOTAL</b>         |                          |                          | \$ _____    | \$ _____     |

2. Date service began \_\_\_\_\_ 3. Date service completed \_\_\_\_\_

PROVIDER'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
 PRINT OR TYPE PROVIDER'S NAME \_\_\_\_\_ TAX I.D. NO. \_\_\_\_\_ TELEPHONE NO. \_\_\_\_\_  
 STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_