

INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCAL UNION NO. 891
EYE CARE PROGRAM **PLAN "A"**

SEND COMPLETED FORMS TO: LOCAL 891 WELFARE FUND, 253 W 35th St. NY, NY 10001 12th Floor (212) 505-5050 EXT. 230

MEMBER PLEASE COMPLETE 1-5

Claim No. _____

1. Member's Full Name _____ Soc. Sec. # _____

2. Member's Address _____ City _____ State _____

Zip Code _____ Tel. # _____

Dependent children are covered up to the end of the calendar month in which they turn age 23

3. If claim is for a DEPENDENT, give name _____ Relation _____ Age _____

4. Present Place of Employment _____ Tel. # _____

5. I understand that this form is for reimbursement purposes to members of Local No. 891 Welfare Fund.

Date _____ 20 _____ Member's Signature _____

In order to process this claim, a copy of the paid bill must be attached

TO BE COMPLETED BY OPTOMETRIST, OPTICIAN OR OPHTHALMOLOGIST

Patient's Name _____

Check one or more: Examination \$ _____

Single Vision Lens _____

Bifocal Vision Lens _____

Contact Lens _____

Other _____

Total Charges \$ _____

Date _____ Signed _____ License No. _____

Address _____ Tel. No. _____

Check One: Ophthalmologist _____ Optician _____ Optometrist _____

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