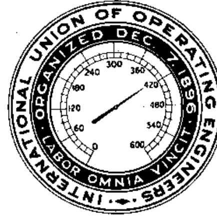

INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCAL 891 WELFARE FUND

LASIK EYE SURGERY BENEFIT REIMBURSEMENT

MEMBER'S NAME ______________________________**SS#** _________________

ADDRESS ____

DATE OF BIRTH __________________ **TOTAL CHARGE** __________________

NAME OF PATIENT ____

RELATIONSHIP TO MEMBER _________________ **BIRTH DATE** ___________

DATE OF SERVICE ____

PLEASE ATTACH PROVIDER INVOICE FOR SERVICES RENDERED AND A COPY OF YOUR EXPLANATION OF BENEFIT IF THE COORDINATION OF BENEFIT RULES APPLY.

PROVIDER NAME ____

PROVIDER ADDRESS ____

I have enclosed an original copy of the provider's basic invoice for services rendered; I have also included any explanation of benefits for any primary or secondary health insurance which I may receive in relation to this procedure. I understand the maximum allowed benefit under this plan is $1,000.00 per family every calendar year.

Signature of Member ___________________________________ Date ___________________

MAIL FORM TO: **Local 891 Welfare Fund**
c/o Daniel H. Cook Associates
253 West 35th Street 12th Floor
New York NY 10001-1907
(212) 505-5050 ext. 229