

**BRICKLAYERS and ALLIED CRAFTWORKERS LOCAL #5 NEW YORK
WELFARE FUND OPTICAL CARE CLAIM STATEMENT**

For the purchase of glasses or for an exam to determine if glasses are needed.

1. Name: _____
Last First Middle Birth Date
2. Address: _____
No. Street City State Zip Code
3. Social Security No. _____ Telephone No. _____
4. IF CLAIM FOR DEPENDENT, give name _____
5. Relationship of dependent to member _____ Birth Date _____
6. Is the person for whom claim is made covered under any other Group Health Plan which provides Optical care?
Yes: _____ No: _____
a. If yes, Indicate name and address of Health Plan or Insurance Company.
- _____ Name of Company Address
- b. Name of Group (employer or Union) through which coverage is provided _____
- c. Address of the office where claims are paid _____
8. Are you filing claim under any Workmans Compensation Law? Yes: _____ No: _____

DOCTOR OR OPTOMETRIST'S STATEMENT

9. Patient's Name: _____ Age: _____
10. Doctor or Optometrist's Record of Procedures
- a. Screening Visual Analysis _____
 - b. Refraction _____
 - c. Review of existing equipment _____
 - d. Other _____
 - e. Diagnosis _____
 - f. Is any of treatment the result of an injury? Yes: _____ No: _____
 - g. If yes, did injury arise out of patient's employment? Yes: _____ No: _____
 - h. Indicate dates on which patient was treated: _____ Exam Charge: \$ _____

Date of prescription: Date eyeglasses given to patient: _____

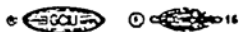
11. Prescriptions:
- a. Detail type of lens, lens strength: _____
Lense Charge: \$ _____
 - b. Type of eyeglasses: _____
 - c. Type of frames _____
Frame Charge: \$ _____
 - d. Repair or replacement: _____
 - e. Details of fee: _____
Total Amount: \$ _____
12. Date _____
Dr. or Optometrist Signature _____ S. S. or T. I. N. No. _____
13. Street: _____ City: _____ State & Zip: _____

ASSIGNMENT

14. I wish the assignment of benefits to be as follows:
- a. Please pay all benefits directly to me.
 - b. Please pay all benefits to doctor or optometrist named above.
15. I have reviewed the foregoing treatment plan. I authorize release of any information relating to this claim.

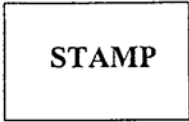
Member's Signature _____

CLAIMS MUST BE FILED WITHIN 180 DAYS OF THE DATE OF TREATMENT OR BENIFITS WILL BE FORTEITED.



SEE INSTRUCTIONS TO MEMBERS ON OTHER SIDE.

**BRICKLAYERS and ALLIED CRAFTWORKERS
LOCAL #5 NEW YORK
WELFARE FUND
126 INNIS AVENUE
POUGHKEEPSIE, NEW YORK 12601-2899**



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ATTENTION TO MEMBERS

1. You **MUST** complete lines 1 thru 8 and lines 14 & 15.
2. Your Doctor or Optometrist must complete his statement (Lines 9 thru 20) or attach an itemized bill.
3. Return this form with any bills.
4. Claims **MUST** be submitted with in 180 days of the date of treatment or benefit will be forfeited.