THE NATIONAL ASBESTOS WORKERS MEDICAL FUND

VISION CARE CLAIM FORM

7130 Columbia Gateway Drive, Suite A
Columbia, Maryland 21046

TELEPHONE
800-386-3632
410-872-9500

THE BENEFIT ALLOWANCE WILL BE PAID TO THE EMPLOYEE ONLY

Print Employee Name _____

Soc. Sec. No. _____

Print Address _____

Has Program Been Used Before? ❑ Yes ❑ No

Print City _____

Print State _____ Zip _____

Telephone Number _____

Company Employed By _____

Any other insurance coverage? Yes ___ No ____ If yes, name of insured _____

Name of insurance company and policy number _____

TO BE SIGNED BY EMPLOYEE:

The undersigned employee certifies that the above information is true and correct and the below services and materials were rendered and supplied as indicated. The undersigned also agrees to pay the doctor for the below services and materials. I hereby authorize the doctor to release the information requested on this form.

Date _____ Signature of Employee _____

Benefit Maximum:

$200 per calendar year for professional fees, materials, lenses and frames.

Sunglasses not provided except in lieu of regular prescription glasses if eligible for same. Broken glasses or frames not covered unless participant eligible for benefits again, and then in lieu of new glasses.

Fees and lenses available once each calendar year — **Frames only every other calendar year.**

TO BE COMPLETED BY DOCTOR (COMPLETE APPROPRIATE ITEMS BELOW)

EXAMINATION FEE: $ _____ OPHTHALMIC MATERIALS: $_____ SINGLE or MULTI-VISION LENSES: $ _____

PATIENT NAME _____ AGE _____ DATE OF EXAMINATION _____

Address of Doctor _____ Signature of Doctor _____

City, State and Zip _____ Type or Print Name and Fed. Tax ID No. _____