

DISTRICT COUNCIL IRON WORKERS WELFARE FUND OF NORTHERN NEW JERSEY

12 Edison Place
Springfield, NJ 07081-1310

OPTICAL BENEFIT CLAIM FORM

Important Information:

- 1. Use this form to request reimbursement for services \*.
2. Expenses for both examinations and eyewear can be listed on this form.
3. Make sure that all sections are completed, that you and the provider(s) have signed the form, and all services, costs and service dates have been entered (or attach signed itemized receipt from provider).
4. Please note that the participant's signature is required on this form.
5. Mail completed form along with original receipts to: District Council Ironworkers Welfare Fund, 12 Edison Place, Springfield, NJ 07081-1310

Participant Information

Participant Social Security #

Participant Name: First Middle Initial Last

Mailing Address: Street City State zip

Telephone: ( )

Patient Information

Patient Name: First Middle Initial Last

Relationship: Participant Spouse Child DOB

Provider Information

Doctor

Dispenser (if different than examining doctor)

Name: Name:

Address: Address:

City: State: Zip: City: State: Zip:

Federal Tax I.D. Number: Federal Tax I.D.

Phone Number: ( ) Phone Number: ( )

Provider Signature Provider Signature

Table with 3 columns: Service, Date of Service, Amount. Rows include Eye Examination, Frames, Single Vision Lenses, Bifocal Lenses, Trifocal Lenses, Contact Lenses, and Total.

Participant Certification

Assignment of Benefits

I certify that the information on this form is correct and authorize the Provider to release appropriate information necessary to process this claim according to plan benefit provisions.

I hereby authorize payment directly to the above Provider for services covered under this Welfare Fund, and otherwise payable to me.

Signature

Signature

Date

Date

\*The use of this form does not guarantee eligibility for this benefit. Eligibility in the Welfare Fund will be verified after this form has been received by the Fund Office.