PLUMBING & PIPEFITTING INDUSTRY
HEALTH AND WELFARE OF KANSAS
625 Enterprise Drive – Oak Brook, IL 60523
PHONE (316) 264-2339 FAX (630) 481-1580 | Email: 441vision@bmgiweb.com

VISION CLAIM FORM

Annual routine eye exams are covered under the Plan through your medical insurance provider (Aetna). The Plan will pay a benefit of $600 per family participant every two calendar years. In addition, the Plan will cover prescription safety glasses (lenses and frames) or contacts in the amount of $400 each calendar year for the ***member*** only. A COPY OF THE LENS PRESCRIPTION & ITEMIZED STATEMENT WITH THE PATIENT NAME LISTED ARE REQUIRED WITH THE CLAIM FORM. The amount per participant is applicable to **"Dates of Service"** within a calendar year. The Fund will not pay on any claim submitted later than one year and 90 days after the service date.

THIS SECTION TO BE COMPLETED BY UNION MEMBER &/OR SPOUSE

MEMBER'S NAME _____ DATE OF BIRTH _____

ADDRESS _____ SOC. SEC. # XXX-XX-_____
Street

_____ HOME PHONE # _____
City State Zip

NAME OF SPOUSE _____ DAYTIME # _____ EMPLOYER _____

DOES THE PATIENT HAVE OPTICAL OR EYE GLASS COVERAGE FROM ANY OTHER SOURCE? YES ☐ NO ☐
(IF "YES", PRIMARY NAME ON INSURANCE: _____, INS. PROVIDER:_____
You must also attach a copy of the Summary (EOB) from the other Insurance Provider. Claim will not be paid out without this documentation).

CLAIM FOR _____ RELATIONSHIP _____ DATE OF BIRTH _____
Name

By signing below, I certify that the above answers, including and accompanying statement, are true and complete. I authorize any physician, hospital or insurance company to disclose any acknowledge or information concerning this or other claims to the Plumbing and Pipefitting Industry Health and Welfare Fund of Kansas, or its' representatives. I expressly waive on behalf of myself and of any person who shall have interest in the benefits, all provisions of the law to the contrary. A photocopy of this authorization shall be as valid as the original.

SIGNED _____ DATE SIGNED _____

PRINT NAME _____ RELATION TO MEMBER _____

STOP!!! FOR HEALTH & WELFARE FUND OFFICE USE ONLY

PREV. PD $_____FOR YEAR_____
AMOUNT OVER $600.00 MAX? _____
DENIAL LETTER COMPLETED BY_____

YEAR
PD $

SERVICE	PROVIDER NAME	DATE	FEE
EYE EXAM			$
LENSES			$
FRAMES			$
CONTACTS			$
SAFETY GLASSES			$
			$
OTHER INSURANCE OR OTHER DISCOUNTS			($)
TOTAL			**$**