



MAIL TO:

FOR OFFICE USE ONLY - DO NOT WRITE ABOVE THIS LINE

Central States Southeast and Southwest Areas
Health and Welfare Fund
Claims Processing - - Vision
PO Box 5105 Des Plaines, IL 60017-5105
1-800-323-5000

MEMBER'S STATEMENT-PLEASE PRINT

Member's Soc. Security Number	Member's First Name	Middle Initial	Last Name	Member's Birth Date	Sex
				Month Day Year	<input type="checkbox"/> M <input type="checkbox"/> F
IF ADDRESS HAS CHANGED SINCE LAST CLAIM, PLACE "X" IN THIS BOX.		Member's Street Address	Member's City & State	Zip Code	
Local Union	Employer Name				
Patient's First and Last Name	Relationship to Member <input type="checkbox"/> Self <input type="checkbox"/> Son <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other (explain) _____			Patient's Birth Date	
				Month Day Year	

PLEASE NOTE: PROVIDER OF SERVICE MUST COMPLETE BELOW SECTION: IF NOT, ATTACH RECEIPTS

TYPE OF SERVICE	Diagnosis _____	PROVIDER OF SERVICE	Dr. _____
	Exam Date _____		Address _____
	Charge \$ _____ 810		City, State, Zip _____
	Purchase Date _____		Tax ID# _____
	Lens Charge \$ _____ /PAIR		Dr/Opt _____
	Lens Type Single Bi Tri Lenti Contact <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vision Focal Focal Cular Lens 821 822 823 824 825		Address _____
Frame Charge \$ _____ 830	City, State, Zip _____		
			Tax ID# _____
			Doctor's Signature _____

PLEASE NOTE: ALL BENEFITS TO BE PAID ARE SUBJECT TO THE 12 MONTH MAXIMUM IN YOUR VISION PLAN. EXTRA CHARGES FOR TINT, SCRATCH COATING, OVERSIZE LENSES, ETC., ARE NOT COVERED UNDER THE TERMS OF THE PLAN.

ASSIGNMENT OF BENEFITS: I hereby assign any benefit under the provision of the Plan to provider(s) listed above.

EXAM

LENS/FRAME

SIGNATURE OF MEMBER

DATE