

# BAC LOCAL UNION 15 WELFARE FUND

6405 Metcalf, Suite 200 • Overland Park, Kansas 66202  
(913) 236-5490 • Fax: (913) 236-5499

## VISION CARE BENEFITS

### EMPLOYEE INFORMATION ~ REQUIRED For All Claims

Home Local Union No. \_\_\_\_\_

Name of Employee \_\_\_\_\_  
(Last) (First) (Middle) Date of Birth \_\_\_\_\_

Employee's Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_

Social Security No. \_\_\_\_\_ Employer \_\_\_\_\_ Active  Retired

Street Address \_\_\_\_\_

City, State \_\_\_\_\_ Zip \_\_\_\_\_ Phone No. ( ) \_\_\_\_\_

### DEPENDENT INFORMATION ~ If Claim Is For Your Dependent

Name of Dependent \_\_\_\_\_

Relationship to Employee \_\_\_\_\_ Date of Birth \_\_\_\_\_

Dependent's Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_

IS DEPENDENT EMPLOYED? IF YES: NAME: \_\_\_\_\_

YES  NO

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

IS DEPENDENT ATTENDING SCHOOL? IF YES: NAME: \_\_\_\_\_

YES  NO

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

**NOTE:** Attach letter from the school with certified transcript stating that Dependant is a full-time student.

### OTHER INSURANCE INFORMATION

Do you or your Dependents have ANY other health insurance?  YES  NO IF YES,

Relationship to Employee \_\_\_\_\_

A) Name of the person insured \_\_\_\_\_

B) Insured person's employer \_\_\_\_\_

C) Employer's street address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

D) Policy Number \_\_\_\_\_ Certificate Number \_\_\_\_\_ Social Security Number \_\_\_\_\_ Phone Number \_\_\_\_\_

**NOTE:** Attach copy of payment worksheet or denial from other insurance or Medicare.

### AUTHORIZATION

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release, when requested by the Trustees or their representative of any facts concerning the treatment of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

### ASSIGNMENT

I hereby authorize payment of Vision Care Benefits directly to the provider(s) of services and materials described on the reverse side of this form.

Employee's Signature \_\_\_\_\_

Date \_\_\_\_\_

## TO BE COMPLETED BY DOCTOR (List Charges)

Name of Patient (Please Print)			Birth of Patient		
			Month	Day	Year
Date of Examination		Date of Patient's Last Examination		Charges for Examination	
Month	Day	Year	Month	Day	Year
Diagnosis:					
Remarks:					
Doctor's Name (Please Print)			Degree		License Number
Doctor's Address				Telephone Number	
City			State		Zip Code
Doctor's Signature				Tax ID Number	

## TO BE COMPLETED BY OPTOMETRIST OR OPTICIAN'S OFFICE

Name of Person for whom services were rendered (Please Print)					
Date Services Provided		Lens Type (Circle One)		Charge for Lenses	Charge for Frames
		<input type="radio"/> SINGLE <input type="radio"/> TRIFOCAL <input type="radio"/> BIFOCAL <input type="radio"/> CONTACT		\$	\$
Month					
Day					
Year					
Optical Agency Name (Please Print)				Signature of Supplier	
Address				Tax ID Number	
City		State	Zip Code	and Title	

I hereby certify that the services listed above have been performed.

DOCTOR/  
OPTOMETRIST/  
OPTICIAN's

Signature \_\_\_\_\_ Date \_\_\_\_\_