INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCAL UNION NO. 891
EYE CARE PROGRAM

PLAN "A"

SEND COMPLETED CLAIMS TO: LOCAL 891 WELFARE FUND, 253 WEST 35TH STREET, 12TH FLOOR, NEW YORK, NY 10001-1907

MEMBER PLEASE COMPLETE 1-5 Claim No. _____

1. Member's Full Name_____ Soc. Sec.# | | | | | | | | | |

2. Member's Address _____ City _____ State_____

   Zip Code _____ Tel. # _____

Dependent children are covered up to the end of the calendar month in which they turn age 23

3. If claim is for a DEPENDENT, give name _____ Relation _____ Age _____

4. Present Place of Employment _____ Tel. # _____

5. I understand that this form is for reimbursement purposes to members of Local No. 891 Welfare Fund.

   Date _____ 20_____ Member' s Signature _____

In order to process this claim, a copy of the paid bill must be attached

TO BE COMPLETED BY OPTOMETRIST, OPTICIAN OR OPTHALMOLOGIST

Patient' s Name _____

Check one or more:		
	Examination	$_____
	Single Vision Lens	$_____
	Bifocal Vision Lens	$_____
	Contact Lens	$_____
	Other	$_____
	Total Charges	$_____

Date _____ Signed _____ License No. _____

Address _____ Tel. No. _____

Check One: Ophthalmologist _____ Optician_____ Optometrist _____