INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCAL UNION NO. 891
EYE CARE PROGRAM **PLAN "A"**

SEND COMPLETED FORMS TO: LOCAL 891 WELFARE, 1040 Avenue of the Americas, 24TH FLOOR, NEW YORK, NY 10018-3726

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 ______________________ 19 __________ Member's Signature ______________________

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

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TO BE COMPLETED BY OPTOMETRIST, OPTICIAN OR OPHTHALMOLOGIST

Patient's Name ______________________

Check one or more:

- ❑ Examination $________
- ❑ Single Vision Lens ________
- ❑ Bifocal Vision Lens ________
- ❑ Contact lens ________
- ❑ Other ________

Total Charges $________

DANIEL H. COOK ASSOCIATES, INC.
1040 Avenue of the Americas, 24TH
FLOOR NEW YORK, NY 10018

Date ______________ Signed ______________________ License No. ______________________

Address ______________________ Tel. No. ______________________

Check One: Ophthalmologist ________ Optician ______ Optometrist ______

Send White copy to Union