INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCAL 891 WELFARE FUND

LASIK EYE SURGERY BENEFIT REIMBURSEMENT

MEMBER'S NAME _____ **SS#** _____

ADDRESS _____

DATE OF BIRTH _____ **TOTAL CHARGE** _____

NAME OF PATIENT _____

RELATIONSHIP TO MEMBER _____ **BIRTH DATE** _____

DATE OF SERVICE _____

PLEASE ATTACH PROVIDER INVOICE FOR SERVICES RENDERED AND A COPY OF YOUR EXPLANATION OF BENEFIT IF THE COORDINATION OF BENEFIT RULES APPLY.

PROVIDER NAME _____

PROVIDER ADDRESS _____

I have enclosed an original copy of the provider's basic invoice for services rendered; I have also included any explanation of benefits for any primary or secondary health insurance which I may receive in relation to this procedure. I understand the maximum allowed benefit under this plan is $4,000.00 per family, per year.

Signature of Member _____ Date _____

MAIL FORM TO: **Local 891 Welfare Fund**
C/o Daniel H. Cook Associates
1040 Avenue of the Americas
24th Floor New York NY
10018-3726 (212) 505-5050