ALLIED BUILDING INSPECTORS

LOCAL 211 INTERNATIONAL UNION OF OPERATING ENGINEERS

WELFARE FUND

225 BROADWAY, 43RD FLOOR, NEW YORK, NY 10007

Phone: (212) 233-2690
Fax: (212) 962-2523

OPTICAL BENEFIT CLAIM

To be completed by member:

Name _____

Home address _____

Social Security Number _____ Tel No. _____

Job Title _____ Agency or Department _____

Date _____ Member's Signature _____

To be completed by Optometrist, Optician, or Ophthalmologist

I have examined - Patient's Name _____ Age _____

to determine whether or not he or she needs corrective vision in the form of eye-glasses.

The Patient: *(Check one)* ❑ needs eye-glasses ❑ does not need eye-glasses

Please provide a breakdown of charges:

Examination	$ _____
Lenses	$ _____ Tinted _____ % with or without frames
Frames	$ _____
Total Charges	$ _____

Name _____

Check One ❑ Optometrist ❑ Optician ❑ Ophthalmologist

Address _____ Tel No. _____

City _____ State _____ Zip _____

Date _____ Signature _____

SUBMIT CLAIM WITH ITEMIZED PAID BILL SHOWING CHARGES AND DATES OF SERVICE

OFFICE USE ONLY

Eligibility verified _____ Amount _____