

EMPLOYEE: IT IS YOUR RESPONSIBILITY TO COMPLETE AND SIGN THE EMPLOYEE'S STATEMENT BELOW:

CLAIM FOR BENEFITS

HOW TO FILE YOUR CLAIM

1. You must FULLY COMPLETE the EMPLOYEE'S STATEMENT and SIGN IT.
2. Attach the bills for the medical expense benefits you are claiming. These bills must be itemized and show the patient's name, condition being treated (diagnosis), type of treatment given, date the expense incurred and the charges made.
3. A Physician's Statement is provided on the back of this form for your convenience.
4. RETURN FULLY COMPLETED FORM with attached medical claims to address below.

EMPLOYEE'S STATEMENT						
Fully Complete For All Claims	Employee's Name (Please Print)		Group Number 41593	Birthday (MO. DA. YR.)		
	Address: Street and No.		City	State	Zip Code	
	I am: <input type="checkbox"/> Active <input type="checkbox"/> Retired		This claim is on: <input type="checkbox"/> Myself <input type="checkbox"/> Wife/Husband <input type="checkbox"/> Dependent Child			
	Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Name of Spouse _____		If yes, give name of spouse and name and address of spouse's employer. Spouse's Birthday _____ Social Sec. No. _____			
Complete For All Claims	Name of Spouse's Employer _____		Address _____			
	What was the sickness or injury?			On what date did it begin?	Date of first expense for this condition	
	Are any of the expenses being claimed covered by:					
	(a) Other group health care plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		(c) A group Blue Cross Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Give name of Employer _____ Other insurance company and policy number _____		Give group number _____ Give certificate number _____			
(b) Government insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		(d) School insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				
What type? _____		Is COBRA applicable? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date of COBRA _____				
If these expenses are covered by other insurance and the other carrier is primary (that is, pays first), don't file this claim until you have received the payment from the other insurance. Submit the explanation of benefits from the other carrier with this claim.						
Complete For All Injuries Employee or Dependent	Date the injury?	Where did the injury occur?		How did the injury occur?		
	Is injury due to automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has or will claim be filed under any Worker's Compensation Act or similar law? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Complete Only For Dependent Claims	Name of dependent		Birthday (MO. DA. YR.)	Relationship of dependent		
					<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed	
Date you covered this Dependent	If child 19 or over is (s)he dependent upon your maintenance and support? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	Is (s)he a full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	If student give name and location of school.					
Complete Only For Disability Claims	From and to what dates were you continuously totally disabled from performing any work?					
	From _____ 20 ____ to _____ 20 ____					
Date you were first able to do any work? _____						
Sign Here	I hereby authorize the release to and use by the ILA Employers Welfare Fund of any medical or other information needed in processing this claim and certify that the above information is correct.					
	Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. I hereby certify to the above statements.					
Date _____ 20 ____ Employee sign here X _____						
ADMINISTRATIVE STATEMENT						
The above Employee's Name, Address, Group Number and Social Security Number are correct <input type="checkbox"/>			Was coverage in effect when expense incurred? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please file claim with:						
ILA EMPLOYERS WELFARE FUND 510 W. BRYAN STREET P.O. BOX 1280 SAVANNAH, GEORGIA 31498-1280			SIGNED _____ DATE _____			
Remarks:						

CLAIM FOR VISION CARE BENEFITS

HOW TO FILE YOUR CLAIM

1. You complete Part A.
2. Have your Physician or Optometrist complete Part B.
3. Have the Supplier complete Part C.
4. Send the completed form to ILA Employers Welfare Fund.

PART A			PATIENT & INSURED INFORMATION												
1. PATIENT'S NAME (First name, middle initial, last name)	2. PATIENT'S BIRTHDAY (MO. DAY. YR.)	3. EMPLOYEE'S NAME (First name, middle initial, last name)													
5. PATIENT'S ADDRESS (Street, city, state, Zip code)	4. IF PATIENT CHILD OVER 19. ARE THEY A FULL TIME STUDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		7. EMP. SOC. SEC. NO. <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"><tr><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td></tr></table>												
6. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>															
10. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policy-Holder and Plan Name and Address and Policy or Medical Assistance Number	8. PATIENT'S RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		9. EMPLOYEE'S GROUP NO. (Or Group Name)												
	11. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN AUTO ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>		12. EMPLOYEE'S ADDRESS (Street, city, state, Zip code)												
13. Does your wife/husband work? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES what is their Employer's name? _____															
14. I hereby authorize the release of any information necessary to process this claim.			Patient's or Authorized Person's Signature		Date										
15. I authorize payment of Vision Care benefits to undersigned Physician or Optometrist for services described below. This authorization is invalid unless the Tax I.D. of the Provider is given below.			Employee's or Authorized Person's Signature		Date										

PART B			EXAMINING PHYSICIAN OR OPTOMETRIST'S INFORMATION		
1. What was the purpose of this examination? _____					
2. Did exam include: Refraction? <input type="checkbox"/> Yes <input type="checkbox"/> No Tonometry? <input type="checkbox"/> Yes <input type="checkbox"/> No					
3. Date of this examination _____ Date of last examination _____					
4. Does patient require a prescription change at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No Do Frames need changing? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES please give reason below.					
Axis change _____ degrees. Diopter, sphere or cylinder change _____					
Will lenses improve visual acuity by at least one line on standard chart? <input type="checkbox"/> Yes <input type="checkbox"/> No					
5. Are any of these charges covered by any other insurance, governmental or workers compensation law? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If YES please identify fully on the back of this form, giving name of other insurance company and name of group.					
6. Charge for this examination \$ _____. Amount paid by insured \$ _____.					
I hereby certify that the above statements accurately describe the services rendered and that I am _____ (Type of physician)					
licensed to practice by the State of _____.					
(Print or type Physician's name)		(Date)		(Signature of Physician)	
MUST BE FURNISHED UNDER AUTHORITY OF LAW					
(Address)		Individual Practitioner's SS No. _____		All Others -- Employer ID No. _____	

PART C			SUPPLIER'S STATEMENT					
The following Lenses and/or Frames were ordered on _____ (Date) for the above patient as prescribed on _____ (Date) by myself or by Dr. _____								
MATERIALS SUPPLIED								
Type of Lens	No of Lens	Charge	Extra charge for Photosensitive or Anti-reflective	Sphere	Cylinder	Axis	Prism	Add
Single vision	_____	\$ _____	\$ _____	OD	_____	_____	_____	_____
Bifocal	_____	_____	_____	OS	_____	_____	_____	_____
Trifocal	_____	_____	_____	Is there any other insurance which covers these charges? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES please describe on the back of this form giving name of insurance company and group.				
Lenticular	_____	_____	_____					
Contact	_____	_____	_____					
Oversize	_____	_____	_____					
Sunglasses	_____	_____	_____					
Tint No.	_____	_____	_____					
Other	_____	_____	_____					
TOTAL LENS CHARGE		\$ _____	\$ _____					
FRAMES CHARGE		\$ _____	Amount paid by Insured \$ _____					
Name of Supplier _____			(Must be Furnished Under Authority of Law)					
Address _____			SS No. _____	Employer I.D. No. _____				
Street	City	State	Zip Code					
Signature _____						Date _____		