Local 371
Amalgamated Welfare Trust Fund

290 POST ROAD WEST — P. O. BOX 470
WESTPORT, CONNECTICUT 06881-0470

OPTICAL PROGRAM

OPTOMETRIST, OPTICIAN, OPHTHALMOLOGIST, ETC. STATEMENT

1. Patient's Name ______________________ Age ________
2. Nature of Defect ______________________
3. Amount of Vision each eye (Snellen Notations, Jaeger Scale) ______________ DATE OF EXAM ____________
   Uncorrected O. D. ______________ O. S. ______________
4. Was patient recommended by Optometrist Yes ________ No ________
5. Did the defect arise out of patient's employment? Yes ________ No ________
   If yes, explain ______________________

Check Service rendered	CHARGE		CHARGE
...... Complete Pair-Bifocal, etc., vision with exam	....	...... Single vision lenses with exam	....
...... Complete Pair-single vision lenses no exam	....	...... Single vision lenses-no exam	....
...... Complete Pair-Bifocal, etc., vision no exam	....	...... Examination	....
...... Complete Pair-Single vision lenses with exam	....	...... Frames Only	....
...... Bifocal, etc., vision lenses with exam	....	...... Contact Lenses, with exam	....
...... Bifocal, etc., vision lenses-no exam	....	...... Contact Lenses, no exam	....

DATE		SIGNATURE	Sign Here
ADDRESS	*(Print Name)*	TAXPAYER IDENTIFICATION NO. (This Information Required Under Authority of Law)	

(Please Type or Print)

EXCLUSIONS AND LIMITATIONS

No Benefits Payable For:

1. Sun Glasses
2. Any service not shown above

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to ______________________ of all optical benefits due me, if any, by reason of services rendered, as provided in the policy. I understand I am financially responsible for charges not covered by the policy.

Date ______________ Member's Signature ______________________ Sign Here

To Be Completed by Member

Mr. ☐
Mrs. ☐ ______________________ Date of Birth ____________ Social Security No. [ ][ ][ ]
Miss ☐ *(Print Member's Name)*

2. Claim is made for ☐ Self ☐ Spouse ☐ Child ______________ *(Print Name)* Date of Birth ____________ Sex ______
3. Home Address (Street and Number) ______________________ Telephone No. ____________
   City ______________ State ______________ Zip Code ________

☐ CHECK BOX IF NEW ADDRESS

4. Member's Company ______________ Full-Time ☐ Part-Time ☐ Address ______________ Sign Here

Date of Hire ___/___/___ Member's Signature ______________________

NOTE — *ITEMIZED* **BILLS** MUST ACCOMPANY ALL CLAIMS Date ___/___/___

To Be Completed by Local 371 Fund

1. Effective Date of Member's benefits ______________ 20 ______ Class ____________
2. If dependent claim, effective date ______________________
3. Employer's Name ______________________
4. Date ______________ 20 ______ Authorized Signature ______________________

FILE WITHIN
30
DAYS