ELECTRICAL WORKERS HEALTH & WELFARE PLAN FOR NORTHERN NEVADA

445 Apple Street ** P. O. BOX 11337
RENO, NEVADA 89510
TELEPHONE (775) 826-7200

request for **VISION BENEFITS**

( ) **CHECK HERE IF NEW ADDRESS**

PART I -- EMPLOYEE COMPLETES

Employee's name ______ Employee's Address ______

LAST FIRST STREET CITY ST ZIP

EMPLOYEE'S SOCIAL SECURITY NUMBER: - -

daytime phone number ( )

Patient's name ______ Patient's Address ______

LAST FIRST STREET CITY ST ZIP

Patient's DATE OF BIRTH:______ Relationship to Employee:______

Is the patient covered by any other insurance plan which provides VISION benefits? YES____ NO_____
If yes, please provide:

Name of Insured Member ______ Social Security Number of Insured Member

Insurance Company Name ______ Address ______ Phone number

PAYMENT AUTHORIZATION: **PAY MEMBER (__)** **PAY PROVIDER (__)** I authorize the administrator in its sole discretion to pay directly to the below named provider any benefits otherwise payable to me, but not to exceed any of the charges by the provider.
I understand that I am financially responsible for any charges not covered by this authorization.

X______
Employee's signature date

I hereby certify that the above statements including any accompanying statements are to the best of my knowledge & belief true and correct.

X______
Employee's signature date

PART II -- PROVIDER COMPLETES (or attach itemized bill)

SERVICE	DATE	CHARGE	SERVICE	DATE	CHARGE
☐ EXAMINATION FEE			☐ FRAMES		
PRESCRIPTION LENSES:			☐ TINT Photogrey/UV		
☐ Single Vision			☐ TINT Rose #1 or #2		
☐ Bifocal			CONTACTS: ☐ cosmetic		
☐ Trifocal			☐ medically necessary		
☐ Lenticular			☐ bifocal		

TOTAL CHARGES $

PRACTICE NAME ______ PRINT PHYSICIAN'S NAME & CREDENTIALS ______ PHONE NUMBER ______

ADDRESS

STREET CITY STATE ZIP

TAX IDENTIFICATION NUMBER

______
(REQUIRED)

I certify that I have performed the services as indicated hereon.

X______
PROVIDER'S SIGNATURE DATE

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VISION BENEFITS

You must be eligible for vision services on the date of service to receive benefits.

If you are not eligible for benefits, you are responsible for payment of the charges.

Complete PART I of the claim form and sign where indicated. Give the completed claim form to the provider of service to complete PART II. Submit the completed form to the Trust Fund Office for consideration of benefits.

This Plan is designed to cover basic visual needs rather than cosmetic materials. When a patient selects any extras or upgrades, the Plan will pay the scheduled allowance of the covered materials and the patient is responsible for any additional cost.

SERVICE	SCHEDULED ALLOWANCE
EXAMINATION FEE	$40.00
PRESCRIPTION LENSES:	
Single Vision	$36.00
Bifocal	$55.00
Trifocal	$70.00
Lenticular	$150.00
FRAMES	$35.00
TINT Photogrey/UV (employee only)	$20.00
TINT Rose #1 or #2 (dependents)	$7.00
CONTACTS: cosmetic	$96.00
medically necessary	$225.00
bifocal	$123.00

Services may be obtained from any ophthalmologist, optometrist, or optician, but certain contracted eye care providers (PPO's) offer complete eye exams and a selection of glasses at no cost to you. Upgraded materials are available from PPO's at a discounted rate. Please see your PPO Directory or contact the Trust Fund Office for a list of these professionals.

The Plan provides the following benefits for eligible individuals once each calendar year: (Jan - Dec)

- Eye examination with refraction
- Contact lenses or glasses (if required)

Employee Benefits: Exam, frames, lenses, photogrey or UV coating or tinting.
Dependent Benefits: Exam, frames, lenses, Rose tint #1 or #2.

NOT COVERED:

1) Plano (non-prescription) lenses.
2) Lenses/frames or contacts furnished under this program which are lost or broken except at the normal intervals when services are available.
3) Services or materials provided as a result of any Worker's Compensation Law.

DUPLICATE COVERAGE: If you or your eligible dependents are also covered by another group vision plan, the benefits payable by this Fund for vision services and materials may be reduced.