


RETURN COMPLETED FORM TO: 

**WASHINGTON-IDAHO CARPENTERS EMPLOYERS HEALTH
& SECURITY TRUST FUND VISION**
P.O. BOX 5434
SPOKANE, WASHINGTON 99205
(509) 328-0300

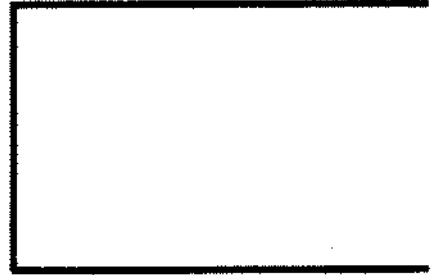
**APPLICATION FOR
VISION CARE
BENEFITS**

Part 1. To Be Completed and Signed by Employee Only

EMPLOYEE'S NAME (FIRST) (LAST)		NAME OF COMPANY YOU WORK FOR (FIRM NAME)	
HOME ADDRESS		MARITAL STATUS	
(CITY)	(STATE)	(ZIP CODE)	HOME TELEPHONE NO. EMPLOYEE SOCIAL SECURITY NO.
CLAIM IS MADE FOR <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD	NAME OF PERSON RECEIVING VISION CARE (FIRST) (LAST)	PERSON RECEIVING VISION CARE <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH OF PERSON RECEIVING VISION CARE
NAME AND ADDRESS OF SPOUSE'S EMPLOYER		IS PATIENT COVERED BY OTHER GROUP PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME, ADDRESS, & PLAN NUMBERS OF ANY OTHER INSURANCE CARRIER ORGANIZATION PROVIDING BENEFITS FOR VISION CARE (INCLUDING DEPENDENTS' INSURANCE)			
WAS VISION CARE REQUIRED BECAUSE OF ANY INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COMPLETE QUESTIONS BELOW.			
WAS INJURY CAUSED BY YOUR WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAVE YOU FILED A CLAIM FOR THIS DISABILITY WITH THE WORKMEN'S COMPENSATION CARRIER? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS VISION EXAMINATION REQUIRED AS A CONDITION OF YOUR EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW DOCTOR OF THE GROUP VISION BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED THE CHARGES SHOWN BELOW. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION.		I HEREBY ACCEPT THE FOLLOWING TREATMENT PLAN AND AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.	
_____ SIGNED (EMPLOYEE) DATE _____		_____ SIGNED (EMPLOYEE) 	

Part 2. To Be Completed by Doctor

- Has cataract surgery been performed? Yes _____ No _____ Date _____
- Can visual acuity be restored to at least 20/70 in the better eye with conventional glasses? _____



PROFESSIONAL SERVICES	DATE	FEE	FOR ADMINISTRATIVE USE ONLY
VISUAL EXAM			
SINGLE VISION LENSES			
BIFOCAL LENSES			
TRIFOCAL LENSES			
LENTICULAR LENSES			
CONTACTS			
FRAME			
OTHER			
TOTAL			

Part 3. To Be Completed by Administrator

- ELIGIBILITY: _____
- CLAIM NO.: _____
- DATE PAID: _____
- AUDITOR: _____

SIGNATURE BY THE DOCTOR CERTIFIES THAT ALL SERVICES LISTED ABOVE HAVE BEEN COMPLETED.

Date _____ Signed _____

Individual Practitioners—SS No. _____
All Others—Employer I.D. No. _____

(TYPE OR PRINT DOCTOR'S NAME) (DEGREE) License Number _____

Phone _____ Address _____ (NUMBER AND STREET) (CITY) (STATE) (ZIP CODE)