MO-KAN SHEET METAL WORKERS WELFARE FUND

P. O. Box 300019
Kansas City, MO 64130
(866) 531- 5488 Toll Free or (816) 753-7252 Fax

STATEMENT OF CLAIM • VISION CARE BENEFITS

TO BE COMPLETED BY ELIGIBLE MEMBER

please print last name ______ first ______ middle ______

address ______

city ______ state ______ zip code ______

date of birth ______ Mo-Kan ID or SSN ______

name of present or last employer ______

Claim is made for:
(check one)
☐ Self
☐ Dependent ______
name of dependent ______ relationship ______ birthdate ______

WERE ANY EXPENSES COVERED BY WORKMAN'S COMPENSATION OR ANYOTHER VISION PLAN?

☐ No
☐ Yes ______
Please explain

______

I certify that the above and attached information is correct.

______
eligible employee's signature ______ date ______

Are you or your family member covered under another group benefits or government plan such as Medicare, an HMO plan, or automobile mandatory no-fault coverage which will also cover any of the medical expenses? ☐ Yes ☐ No. If yes, give name of insurance company, organization, or HMO providing benefits.

ATTACH COPIES OF PAYMENT OR EXPLANATION OF DENIAL PROVIDED BY OTHER PLAN.

Covered Family member ☐ Self ☐ Patient ☐ Spouse ☐ Other: specify name & relationship			**Name and address of insurance company**
Policy or plan no.	**Insurance ID number**	**Type of Coverage** ☐ Individual ☐ Family	Is patient employed? ☐ Yes If yes, Name of Employer. ______ ☐ No

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

TO BE COMPLETED BY THE DOCTOR

date service began ______ date service completed ______

print or type doctor s name ______ degree ______

Doctor's address ______

city state zip code ______ telephone number ______

Doctor's signature ______

INDIVIDUAL PRACTITIONERS S.S. # ______

ALL OTHERS-EMPLOYER I.D. # ______

Must be furnished
under authority of law

		Exam/Refraction	$	______
one ☐	two ☐	Frames	$	______
one ☐	two ☐	Lenses	$	______
one ☐	two ☐	Safety glasses with permanency side shields	$	______
one ☐	two ☐	Contacts	$	______
		Contact Lens Fitting	$	______
		Misc.	$	______
		TOTAL CHARGES	$	______

ATTACH
ITEMIZED
RECEIPTS