MO-KAN SHEET METAL WORKERS WELFARE FUND

P.O. Box 300019
Kansas City, Missouri 64130-0019

(816) 531-0334

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 number _____

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 and relationship			Name and address of insurance company
Policy or plan no.	Insurance ID number	Type of coverage ☐ Individual ☐ Family	Is patient employed ☐ No ☐ Yes If yes, give name and address of employer.

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.

WE DO NOT ASSIGN BENEFITS TO THE PROVIDER ON VISION CLAIMS

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

Examination	one ☐	two ☐	$ _____
Frames	one ☐	two ☐	$ _____
Lenses	one ☐	two ☐	$ _____
Safety glasses with permanency side shields	one ☐	two ☐	$ _____
Contacts	one ☐	two ☐	$ _____
Misc.			$ _____
TOTAL CHARGES			$ _____

ATTACH ITEMIZED RECEIPTS