VISION CLAIM FORM	
ullico	

The Union Labor Life Insurance Company

**Communications Workers Local 1109** Welfare Fund

Tel. No.: (718) 444-1119

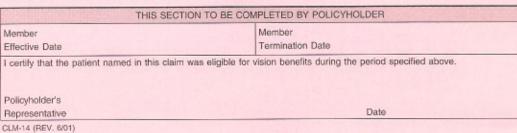
c/o The union Labor Life Insurance Company

P.O. Box 61593

King of Prussia, PA 19406

(Toll Free) Tel. No.: 1-877-800-2956

Member's Name (print in full)					Policy or Plan No. Social Security Number											
					C-39	968			_			]-				
Home Address					Date of Birt	th	Dayt	ime F	hone	Nu	mber					
					Marital Stat	tus	Worl	k Sta								
					☐ Single ☐ Divorced ☐ Active ☐ Disabled ☐ Married ☐ Widowed ☐ Retired ☐ Other (specify)											
City State Zip						ed 🗌 Widowed		-		_		specify	)			
PATIENT INFORMATION						SPOUSE INFORMATION  Date of Birth										
Name		Date of E	sirth	Name							Dair	OI DII	di.			
Social Security Number Relationship to Member			Sex	Social 5	Security Nu	mher			-	_	Emi	oloyme	nt Str	atus		_
Self Spouse			☐ Male	000111			_	_		•	100000	Active			ed	
☐ Child ☐ Other (specify)			☐ Female									Not Er	nploy	ed		
	married? a full-time student?		☐Yes ☐No ☐Yes ☐No	Empl	oyer Name	and Address										
	adult, patient's signatur for Release of Informa															
If treatment is for an injury, desc		YOU	it occurred.													
		Did inion				Was injuny cause	od bu	a mo	tor val	nich	hinne a	ant?				
Date injury occurred		Did injury occur at work?	,	□Y	☐Yes ☐No Was injury caused by a motor vehicle accident? ☐Yes ☐No											
	Y MEMBER OF YOUR			OTHER	GROUP VI			_		_	OWING	SECT	ION.			
Covered Family Member				_		ss of Insurance C										
☐ Self ☐ Patient																
☐ Spouse ☐ Other: specify																
Policy or Plan No.	Insurance ID Number		Type of Coverage  Individual Family													
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.																
AUTHORIZATION FOR RELEASE OF INFORMATION: I/We authorize the release to ULLICO and its agents of any evidence or information about me or my dependents that may pertain to this or any related claim. A copy of this authorization shall be as valid as the original.  (Patient's signature is required if patient is a legal adult.)																
Member's Signature			Date	Patie	nt's Signatu	ure								Da	ate	HE S
INSTRUCTIONS FOR MAKING			er all required question												<b>6</b> 0	
If you want us to pay the hosp     Have the doctor complete his type, place and date of each ser	section or attach an ite	mized bill indic	nment of Benefits" s ating the patient's na	ection on ame, diag	the reverse gnosis, the	е.										
	THIS SECTION TO BE		BY POLICYHOLDE	R												



ASSIGNMENT
OF
BENEFITS

I authorize payment of benefits to the undersigned physician or supplier for the services described below.

Member's Signature

Date

PHYSICIAN OR SUPPLIER INFORMATION: These sections to be completed by physician unless claim is submitted with an itemized bill.

	N OR SUPPLIER INFORMAT		ons to be completed by pr			Dill.				
NO THE LESS OF THE	18 10 / 15	DATE		CHARGES						
NO. LINE STEEL STREET	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ORDERED	LENSES	TINTING*	FRAMES	TOTAL				
T										
					•					
CHARGES FOR LE	ENSES AND FRAME	S								
ROUTINE EYE EXAMINATION DATE: CHARGE: .										
TOTAL CHARGES FOR ROUTINE EYE EXAMINATION, LENSES, AND FRAMES:										
#TINTING Is tint prescribed?										
OTHER SERVICES. This form is for reporting claims payable under a Vision Care benefit, which usually covers only the following (subject to certain limitations):  (1) Routine eye examinations for determining general eye health and evaluating visual function, including prescription for correction of visual problems; and  (2) Pairs of eyeglass lenses or contact lenses prescribed as a result of such an examination, and eyeglass frames.  However, some policies include a Subnormal Vision Care benefit, which covers other services for improvement of vision in individuals with less than 20/70 visual acuity in the better eye. Describe any such services in the section below.  ADDITIONAL SERVICES, EQUIPMENT OR SUPPLIES PROVIDED OR PRESCRIBED FOR SUBNORMAL VISION CARE  DATE PROVIDED  CHARGE										
						•				
IMPROVEMENT OF VISION	LEFT EYE	RIGHT E	YE BOT		Charges for					
Vision without aid or before treatment					rmal Vision Care					
Vision with aid or after treatment					Charges for ion Care					
Physician's or Supplier's Name, Address, and Phone Number (print)  COMPLETE THE SECTION BELOW IF BENEFITS ARE ASSIGNED. ULLICO WILL NOT ACCEPT AN ASSIGNMENT OF BENEFITS WITHOUT THE PHYSICIAN'S OR SUPPLIER'S TAX IDENTIFICATION NUMBER.  Patient's Account Number  Amount										
			Provider	Provider's Tax ID Number  Balance  Due						