Operating Engineers Local #49 Health & Welfare Fund

Vision Claim Form – Actives & pre-Medicare Retirees

TO BE COMPLETED BY THE PARTICIPANT/POLICYHOLDER

1. Participant/Policyholder Information

   Name: _____

   ID Number: _____

   Date of Birth: _____

   Address: _____

   _____

2. Patient Information (if same as Participant/Policyholder, print SAME)

   Name: _____

   Date of Birth: _____

   Address: _____

   _____

3. Do you have other vision coverage? _____ YES* _____ NO
   **If YES, please provide a copy of the Explanation of Benefits.*

4. Please Attach an Itemized Receipt Showing:

   - Provider's Name and Address
   - Patient's Name
   - Date, Place and Type of Service
   - Itemized Charges

I hereby certify that the statements provided above, as well as the supporting documentation are true and accurate in every way.

Signature: _____ Date: _____

Phone Number: _____

Return completed form to:

Wilson-McShane Corporation
Attn: Claims Department
3001 Metro Drive – Suite 500
Bloomington, MN 55425

Phone: (952) 854-0795
Toll Free: (800) 535-6373
Fax: (952) 851-3521