

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
2002 London Road – Suite 300
Duluth, MN 55812

Phone: (218) 728-4231
Toll Free: (800) 570-1012
Fax: (218) 728-4773