

**PLUMBING & PIPEFITTING INDUSTRY
HEALTH AND WELFARE FUND OF KANSAS**
505 S. BROADWAY, STE. 117 - WICHITA, KS. 67202-3922
PHONE (316) 264-2339 WWW.PPI-FUND.ORG FAX (316) 264-9245

V I S I O N C L A I M F O R M

The Plan will pay a benefit of \$400.00 per **FAMILY** beginning January 1 and ending December 31. Claim forms are available at the Fund Office, Union Hall, or our Web site: www.ppi-fund.org. **A COPY OF THE LENS PRESCRIPTION & AN ITEMIZED STATEMENT ARE REQUIRED WITH THE CLAIM FORM.** The \$400 per family is applicable to "**Dates of Service**" after December 31, 2007. The Fund will not pay on any claim submitted later than 15 months after the service date.

THIS SECTION TO BE COMPLETED BY UNION MEMBER &/OR SPOUSE

MEMBER'S NAME _____ DATE OF BIRTH _____

ADDRESS _____ SOC. SEC. # _____
Street

City State Zip HOME PHONE # _____

EMPLOYER _____

NAME OF SPOUSE _____ SPOUSE'S WORK # _____ EMPLOYER _____

DOES THE PATIENT HAVE OPTICAL OR EYE GLASS COVERAGE FROM ANY OTHER SOURCE? YES NO ; (IF "YES",
PRIMARY NAME ON OTHER INSURANCE: _____, INS.PROVIDER: _____
You must also attach a copy of the Summary (EOB) from the other Insurance Provider. Claim will not be paid without this documentation).

CLAIM FOR _____ RELATIONSHIP _____ DATE OF BIRTH _____
Name

By signing below, I certify that the above answers, including any accompanying statements, are true and complete. I authorize any physician, hospital or insurance company to disclose any knowledge or information concerning this or other claims to the Plumbing and Pipefitting Industry Health and Welfare Fund of Kansas, or its' representatives. I expressly waive on behalf of myself and of any person who shall have any interest in the benefits, all provisions of the law to the contrary. A photocopy of this authorization shall be as valid as the original.

SIGNED _____ DATE SIGNED _____

PRINT NAME _____ RELATION TO MEMBER _____

STOP!!! FOR HEALTH & WELFARE FUND OFFICE USE ONLY

PREV. PD \$ _____ FOR YEAR _____
AMOUNT OVER \$400 MAX? \$ _____
DENIAL LETTER COMPLETED BY _____

YEAR

PROVIDER OF EYE EXAM? _____ DATE _____ FEE \$ _____

PROVIDER OF LENSES? _____ DATE _____ FEE \$ _____

PROVIDER OF FRAMES? _____ DATE _____ FEE \$ _____

PROVIDER OF CONTACTS? _____ DATE _____ FEE \$ _____