

**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

**VISION CLAIM FORM**

The Plan will pay a benefit of \$400.00 per **FAMILY** beginning January 1 and ending December 31. The \$400.00 benefit limit does not apply to dependent children under 18. 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 \$400.00 per family is applicable to "**Dates of Service**" within any calendar year. 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 \_\_\_\_\_  
IS CHILD UNDER 18? \_\_\_\_\_

YEAR

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

PROVIDER OF LENSES? \_\_\_\_\_ DATE \_\_\_\_\_ FEE \$ \_\_\_\_\_

PROVIDER OF FRAMES? \_\_\_\_\_ DATE \_\_\_\_\_ FEE \$ \_\_\_\_\_

PROVIDER OF CONTACTS? \_\_\_\_\_ DATE \_\_\_\_\_ FEE \$ \_\_\_\_\_