UFCW NATIONAL HEALTH AND WELFARE FUND
66 GRAND AVENUE, ENGLEWOOD, NEW JERSEY 07631
(201) 569-8801 FAX (201) 569-1085
www.ufcwnationalfund.org

VISION SERVICES CLAIM FORM

MEMBER PLEASE PRINT 1-5 BELOW

1. Member's Full Name_____ Soc.Sec/ID. # ☐☐☐ ☐☐ ☐☐☐☐

2. Member's Address_____

   City_____ State_____ Zip Code_____Tel. #_____

3. If claim is for a DEPENDENT, give Name_____ Relation_____ Age_____

4. Present Place of Employment _____Tel. # (_____) _____

5. I understand that this form is for reimbursement purposes to participants of the UFCW National Health and Welfare Fund that do not have a vision Plan under their Plan of Benefits in their Summary Plan Description.

   Date_____20____Member's Signature _____

In order to process this claim, a copy of the paid bill must be attached

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TO BE COMPLETED BY OPTOMETRIST, OPTICIAN OR OPHTHALMOLOGIST

Patients Name_____

Check one or more:

- ☐ Examination $_____
- ☐ Single Vision Lens _____
- ☐ Bifocal Vision Lens _____
- ☐ Contact Lens _____
- ☐ Other _____

Total Charges $_____

Date_____ Signed _____License No._____

Address _____Tel. #_____

Check One: Ophthalmologist_____Optician_____Optometrist_____

Send completed form to: **UFCW National Health & Welfare Fund**
66 Grand Ave.
Englewood, NJ 07631

For Office Use: Processed by _____Date_____ Claim No._____

VisionServiceClaimForm.direct_reimbursement.03042021