



# IRON WORKERS'

## Tri-State Welfare Fund

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 Itasca, Illinois 60143  
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 Fax 630-967-3080  
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### VISION CARE

<b>MEMBER INFORMATION — REQUIRED FOR ALL CLAIMS</b>		HOME LOCAL UNION No. _____
NAME OF MEMBER _____		
LAST	FIRST	MIDDLE
MEMBER'S MARTIAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED		
SOCIAL SECURITY NUMBER: _____ OCCUPATION: _____ <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED		
STREET ADDRESS: _____		
CITY, STATE _____ ZIP: _____ PHONE NUMBER (____) _____		
<b>DEPENDENT INFORMATION — IF CLAIM IS FOR YOUR DEPENDENT</b>		
NAME OF DEPENDENT: _____		
RELATIONSHIP TO MEMBER: _____		DATE OF BIRTH: _____
DEPENDENT'S MARTIAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED		
IS DEPENDENT EMPLOYED?   If YES:   NAME: _____		
<input type="checkbox"/> YES <input type="checkbox"/> NO   ADDRESS: _____		
CITY, STATE: _____ ZIP: _____		
IS DEPENDENT?   If YES:   NAME: _____		
<input type="checkbox"/> YES <input type="checkbox"/> NO   ADDRESS: _____		
CITY, STATE: _____ ZIP: _____		
<i>Note: Attach letter from school with certified transcript stating that Dependent is a full-time student.</i>		
<b>OTHER INSURANCE INFORMATION</b>		
DO YOU OR YOUR DEPENDENT HAVE ANY OTHER HEALTH INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO   If YES:		
A) NAME OF THE PERSON INSURED: _____		RELATIONSHIP TO MEMBER: _____
B) INSURED PERSON'S EMPLOYER: _____		
C) EMPLOYER'S STREET ADDRESS: _____		
CITY, STATE: _____ ZIP: _____		
D) POLICY NUMBER: _____		CERTIFIED NUMBER: _____
SOCIAL SECURITY NUMBER: _____ PHONE NUMBER: (____) _____		
<i>Note: Attach copy of payment worksheet or denial from other insurance or Medicare</i>		
<p><b>Authorization</b>  <i>I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release, when requested by the Trustees or their representative, of any facts concerning the treatment of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original.</i></p> <p>Member's Signature: _____ Date: _____</p> <p>Patient's Signature: _____ Date: _____</p>	<p><b>Assignment</b>  <i>I hereby authorize payment of Vision Care Benefits directly to the provider(s) of services and materials described on the next page of this form.</i></p> <p>Member's Signature: _____ Date: _____</p>	

