SHEET METAL WORKERS
LOCAL NO. 110 HEALTH FUND

Administered by Southern Benefit Administrators, Incorporated

Mailing Address:
P.O. Box 1449
Goodlettsville, TN 37070-1449

Telephone: (615) 859-0131
Toll Free: (800) 831-4914
Fax: (615) 855-6159

Street Address:
2001 Caldwell Drive
Goodlettsville, TN 37072-3589

VISION CARE CLAIM FORM

Important: Please complete this form accurately and completely. The form must be signed and dated.

TO BE COMPLETED BY EMPLOYEE

Employee Name_____ ☐ Married ☐ Single Age_____ Sex_____ Phone_____

Street Address _____ City _____ State_____ Zip_____

Social Security Number _____

Are group health insurance benefits payable from any other source for this submitted expense? ❑ Yes ❑ No
If yes, please provide: (a) Insuring Organization _____
(b) Employer_____

IF CLAIM IS FOR DEPENDENT ANSWER THE FOLLOWING QUESTIONS

Dependent Name _____ ☐ Married ☐ Single Age_____ Sex_____ Relationship_____

Street Address of Dependent _____ City _____ State_____ Zip_____ Dependent's Employer_____

EMPLOYEE AUTHORIZATION

Employer_____

Date: _____

I authorize release to Sheet Metal Workers Local No.110 Health Fund of any information required to process my claim. A photocopy of this authorization may be honored.

_____
Employee's Signature

I authorize payment directly to the provider of service.

_____
Employee's Signature

SECTION TO BE COMPLETED BY DOCTOR

Patient's Name _____ Patient's Address _____

Was a prescription written? ☐ Yes ☐ No Initial Glasses or Replacement? _____

If replacement, indicate the change in diopter and degree of axis from prior prescription:

_____

Are lenses for sunglasses? ☐ Yes ☐ No Date of Prior Prescription _____

INDICATE CHARGES FOR SERVICES AND MATERIALS

Examination: ☐ Yes ☐ No Date _____ Fees Charged _____

Lenses Furnished: ☐ Yes ☐ No Date_____ Fees Charged_____
If yes, choose type by selecting the appropriate box: Fees Charged _____
☐Single Vision ☐Bifocal Date of Delivery_____
☐Trifocal ☐Lenticular ☐Contacts

Frames: ☐ Yes ☐ Date _____ Fees Charged_____

TOTAL COST TO PATIENT: Fees Charged_____

Date _____ State License Reg. No. _____ Tax I.D. No. _____

Print Doctor Name_____ Doctor's Signature_____

Doctor's Address _____