PLUMBING & PIPEFITTING INDUSTRY
HEALTH AND WELFARE OF KANSAS
505 S. BROADWAY, STE 117 – WICHITA, KANSAS 67202-3922
PHONE: (316) 264-2339 FAX: (316) 264-9245 EMAIL: FUNDOFFICE@PPI-FUND.ORG

VISION CLAIM FORM

The Plan will pay a benefit of $600.00 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 & ITEMIZED STATEMENT WITH THE PATIENT NAME LISTED ARE REQUIRED WITH THE CLAIM FORM. The $600.00 per family is applicable to **"Dates of Service"** within a calendar year. The Fund will not pay on any claim submitted later than one year and 90 days after the service date.

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

MEMBER'S NAME _____ DATE OF BIRTH _____

ADDRESS _____ SOC. SEC. # _____
Street

_____ HOME PHONE # _____
City State Zip

EMPLOYER _____

NAME OF SPOUSE _____ DAYTIME # _____ EMPLOYER _____

DOES THE PATIENT HAVE OPTICAL OR EYE GLASS COVERAGE FROM ANY OTHER SOURCE? YES____NO___
(IF "YES", PRIMARY NAME ON INSURANCE: _____, INS. PROVIDER: _____
You must also attach a copy of the Summary (EOB) from the other Insurance Provider. Claim will not be paid out without this documentation).

CLAIM FOR _____ RELATIONSHIP _____ DATE OF BIRTH _____
Name

By signing below, I certify that the above answers, including and accompanying statement, are true and complete. I authorize any physician, hospital or insurance company to disclose any acknowledge 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 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 $600.00 MAX?_____
DENIAL LETTER COMPLETED BY_____

YEAR
PD $

PROVIDER OF EYE EXAM? _____ DATE _____ FEE $ _____

PROVIDER OF LENSES? _____ DATE _____ FEE $ _____

PROVIDER OF FRAMES? _____ DATE _____ FEE $ _____

PROVIDER OF CONTACTS? _____ DATE _____ FEE $ _____

$ _____

OTHER INSURANCE OR OTHER DISCOUNTS …… ($ _____)

TOTAL …… $ _____