Carpenters' Local No. 491
Health and Welfare Plan
911 Ridgebrook Road
Sparks, Maryland 21152-9451
Toll Free Telephone (888) 494-4443
www.associated-admin.com

Vision Benefit Claim Form

SECTION I: TO BE COMPLETED BY PARTICIPANT

Participant's Name: _____
(Last) (First) (Middle)

Social Security Number: _____ Date of Birth: _____
(Mo./Day/Yr.)

Address: _____
(Number and Street) (City) (State) (Zip Code)

Patient's Name: _____
(Last) (First) (Middle)

Patient's Date of Birth: _____ Relationship to Participant: ☐ Self ☐ Child ☐ Other: _____
(Mo./Day/Yr.)

I authorize payment to be made to: ☐ Provider ☐ Participant (Insured)

Signature of Participant: _____ Date: _____

SECTION II: TO BE COMPLETED BY PHYSICIAN

Date of Service	Type of Service	Amount Charged

Provider's Name: _____ Provider's Phone Number: (___) _____

Provider's Taxpayer Identification Number: _____

Provider's Address: _____
(Number and Street) (City) (State) (Zip Code)

Patient's Account Number: _____ Has there been any change in prescription? ☐ Yes ☐ No

Signature of Provider: _____ Date: _____