ILWU-PMA WELFARE PLAN ▪ 1188 FRANKLIN STREET, SUITE 101 ▪ SAN FRANCISCO, CA 94109
(415) 673-8500

OPHTHALMOLOGY BENEFIT CLAIM FORM

TO BE COMPLETED BY EMPLOYEE:

Employee Name _____ Local _____ Reg.No. _____

Employee Social Security Number: _____-_____-_____

(Street Address) (City) (State) (Zip Code)

(Patient Name) (Relation to Employee)

(Employee Signature) (Date)

Attach to this form:

1. Vision Service Plan explanation of vision care benefit reimbursement (attached to VSP check) or (Washington eligibles) copy of VSP check.

2. Itemized bill for routine eye examination by an ophthalmologist.

Mail to: ILWU-PMA Coastwise Claims Office
P.O. Box 429101
San Francisco, CA 94142

FOR CLAIMS OFFICE USE ONLY

Date of Examination _____

Charges: $_____

less VSP reimbursement . . . . . ($_____)

deductible . . . . ($_____5.00__)

Ophthalmology Benefit Payment . . . . . $_____

Check No. _____ Date _____