SHEET METAL WORKERS LOCAL UNION NO. 32
HEALTH AND WELFARE FUND

Zenith Administrators
P.O. Box 721380
Houston, TX 77272-1380
713-219-1200 or Toll Free 866-521-7632

Important Information:

1. Use this form to request reimbursement for services received from your Vision care provider.
2. Expenses for both examinations and eyewear can be claimed on this form.
3. Make sure that all sections are completed, that you and the provider(s) have signed the form, and that all services, charges and service dates have been entered (or a signed itemized receipt from provider has been attached).
4. Please note that the **member's** (or employee's) signature is required on this form.
5. Mail completed form along with original receipts to: ***SHEET METAL WORKERS LU 32 H&W FUND*** at the address shown above.
6. If you and your spouse are both members, you may be covered both as a member and as a dependent of a member. Similarly, your dependents may or may not be covered by both members. Please verify your coverage with the Fund Office or call: ***866-521-7632***.

Member/Employee Information

** Your Member Identification No. is the number by which the company that sponsors your vision care benefits identifies you.*

(PLEASE PRINT CLEARLY)

Member Name: ______________________ (First, Middle Initial, Last)

Member Identification No.*: ______________________

Member Social Security No.: ______________________
(complete if different than Identification No.)

Mailing Address: ______________________ (Street, City, State, Zip)

Business Phone: ______________________ (Area Code)

Home Phone: ______________________ (Area Code)

Patient Information

Patient Name: ______________________ (First, Middle Initial, Last)

Relationship: ☐ Member ☐ Spouse ☐ Child DOB: __________ ☐ If student aged 19 or over, attach written proof of attendance at school (if required)

Are you and your spouse's benefits both provided by the same agency? ☐ Yes ☐ No

Provider Information

Examiner

Name: ______________________

Address: ______________________

City: __________ State: ____ Zip: __________

Federal Tax I.D. Number: ______________________

Phone Number: ______________________

Provider Signature: ______________________

Dispenser

Name: ______________________

Address: ______________________

City: __________ State: ____ Zip: __________

Federal Tax I.D. Number: ______________________

Phone Number: ______________________

Provider Signature: ______________________

Service	Date of Service	Amount
1. Eye Examination		$
2. Frames		$
3. Single Vision Lenses (not plano)		$
4. Bifocal Lenses		$
5. Trifocal Lenses		$
6. Contact Lenses		$
7. Cataract S.V. Lenses		$
8. Cataract Bifocal Lenses		$
9. Medically Necessary Contact Lenses		$
Total		$

Member/Employee Certification

I certify that the information on this form is correct and authorize the Provider to release appropriate information necessary to process this claim to plan benefit provisions.

______________________ ______________

Member/Employee or authorized person's signature **Date**