National IAM Benefit Trust Fund
1300 Connecticut Ave., NW, Suite 300
Washington, DC 20036
Tel: 202-785-8148 or 1-800-457-3481
Fax: 202-728-0585

INSTRUCTIONS:
1. TYPE or PRINT so information is legible.
2. Complete "Employee", "Dependent" (if applicable), and "General" sections in full.
3. Sign and date "Certification and Authorization" section.
4. Have your Vision Care Provider complete "Provider Statement" in full.
5. Attach your itemized receipt for all services and submit within one year of services.

☐ Check if your address has changed since your last enrollment form was completed.

VISION CARE CLAIM FORM

EMPLOYEE INFORMATION (Complete this section for all claims)

1. Employee name: _____ 2. Employee SSN: _____
3. Employee address: _____
4. Employee date of birth: _____ 5. Employee phone number: _____
6. Employer name: _____ 7. Employee status: ☐ Active ☐ Retired ☐ COBRA ☐ Disabled

DEPENDENT INFORMATION (Complete only if patient is other than employee)

8. Dependent name: _____ 9. Dependent SSN: _____
10. Dependent address (if different than employee): _____
11. Dependent date of birth: _____ 12. Dependent relationship to employee: _____
13. At time of service was this dependent: ☐ Employed ☐ Student ☐ Neither 14. Dependent phone number: _____
15. If employed, name of employer: _____ ☐ Full time ☐ Part time

GENERAL INFORMATION (Complete this section for all claims)

16. Does patient have other vision plan coverage? ☐ Yes ☐ No 17. If yes, subscriber name: _____
18. Name of other plan: _____ 19. Policy number: _____
20. Other plan address: _____ 21. Phone number: _____
22. Effective date: _____ IF OTHER PLAN IS PRIMARY, ATTACH A COPY OF OTHER PLAN'S EXPLANATION OF BENEFITS STATEMENT.
23. Are any expenses the result of accident or injury? ☐ Yes ☐ No 24. If yes, date of incident: _____
25. Are any expenses covered by Workers' Compensation? ☐ Yes ☐ No 26. If yes, explain: _____

EMPLOYEE CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that the above and any attached information is true and correct, and I authorize all vision care providers to furnish the National IAM Benefit Trust Fund or its legal representative with any information necessary to process this claim.

EMPLOYEE SIGNATURE: _____ DATE SIGNED: _____

PROVIDER STATEMENT

Patient name: _____ Service date: _____

SERVICES PROVIDED (Use description line below, the reverse side of this form, or your attached itemized receipt to describe services where necessary):

Number of Lenses	Lenses	Fee	Exams / Contacts	Fee	Frames / Other	Fee
☐ one ☐ two	Single Vision $		Examination $		Frames $	
☐ one ☐ two	Bifocal $		Refraction $		Transitions $	
☐ one ☐ two	Trifocal $		Contact Lens Fitting $		Tints & Coatings $	
☐ one ☐ two	Progressive $		Contact Lenses $		Other (describe) $	

Diagnosis for exam: _____ Describe "Other": _____

Was a discount given? ☐ Yes ☐ No If yes, ☐ percent: _____ ☐ amount: _____ TOTAL CHARGES: _____

PROVIDER NAME / DEGREE: _____ PHONE NUMBER: _____

ADDRESS: _____ FAX NUMBER: _____

I certify that all services were provided to this patient as noted above and/or on the attached itemized receipt from my office for this date of service.

PROVIDER SIGNATURE: _____ DATE SIGNED: _____

NOTE: VISION PLAN BENEFITS ARE PAID DIRECTLY TO THE ELIGIBLE EMPLOYEE. THIS PLAN DOES NOT ACCEPT ASSIGNMENT.