## Central Illinois Carpenters Health and Welfare Trust Fund

## Prescription Safety Glasses Claim Reimbursement Form - to be Completed by Member

(this benefit became effective July 1, 2018 and applies to members only, not spouses or dependents)

| **PLEASE PRINT and COMPLETE IN FULL to PREVENT DELAY IN PROCESSING** | | | | |
|---|---|---|---|---|
| 1. MEMBER FIRST NAME | LAST NAME | | | |
| 2. MAILING ADDRESS | CITY | STATE | ZIP | 3. TELEPHONE NUMBER<br>(_____) _____ - _____ |
| 4. DATE OF BIRTH | | | | 6. _____ FEMALE<br>_____ MALE |
| 5. SOCIAL SECURITY NUMBER *or* MEMBER ID # (on health plan card) | | | | |
| 7. _____ SINGLE _____ MARRIED _____ WIDOWED _____ LEGALLY SEPARATED _____ DIVORCED | | | | |
| 8. PROVIDER NAME | | | | |
| 9. PROVIDER ADDRESS | | | | |
| 10. PROVIDER PHONE | 11. DATE OF SERVICE | | | |

12. AMOUNT REQUESTED FOR REIMBURSEMENT $ _____ ***Copy of Paid Receipt MUST be Attached****

(reimbursement amount not to exceed $100 every 12 consecutive months from last date of service)

* Paid Receipt must include Provider's name, address and phone number; member's name; lens and frame information designating prescription safety glasses.

13. I understand that I must be eligible for the Central Illinois Carpenters Health and Welfare Plan on the date of service for my prescription safety glasses to be eligible for a reimbursement. I understand this prescription safety glasses benefit is for members only (spouses and dependents are not eligible) and that the CIC Health and Welfare Plan will reimburse only me and not my provider (benefit not to exceed $100 every 12 consecutive months).

I understand that I must submit my claim for reimbursement within one (1) year of the date of service to be eligible for reimbursement and any prescription safety glasses claim submitted to the Fund Office after this timeframe will not be eligible for reimbursement.

**Any person who knowingly, and with intent to defraud the Fund or other person, files an application for insurance benefits or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, will be commiting a fraudulent insurance act, which is a crime.**

SIGNATURE OF MEMBER _____ DATE _____

**14. RETURN COMPLETED FORM and ITEMIZED RECEIPT TO:** CENTRAL ILLINOIS CARPENTERS H&WTF, 200 S. MADIGAN DRIVE, LINCOLN, IL 62656

**FAX:** (217) 732-7799 **PHONE:** (217) 732-1919 **OFFICE HOURS**: 8 am - 4:30 pm Monday-Friday

***FUND OFFICE USE ONLY*** Date Received Form: _____ Date of Last Reimbursement: _____

Date Reviewed: _____ Amount to Reimburse: _____ Date Paid: _____

(Form Revised 7-14-18)