SHEET METAL WORKERS (LOCAL UNION NO. 28)
VISION BENEFIT PLAN
195 MINEOLA BLVD., MINEOLA, NEW YORK 11501
TEL.: (516)742-9478 FAX: (516)742-6360

APPLICATION FOR VISION BENEFITS

(Please Print)

NAME:_____
(Last) (First)

ADDRESS:_____
(No.) (Street) (Apt.#) (City) (State) (Zip)

LAST 4 DIGITS OF SS#: _____ TELEPHONE NO.: _____

PATIENTS NAME _____ DATE OF SERVICE: _____

You are eligible for up to $150 reimbursement benefit if:

- You had vision services at a non-participating provider
- You had not previously received Vision Care Benefits in 12 months
- A separate form must be submitted for each patient
- You had an exam/material (frames and lenses)
- You submit this completed application

DATE: _____ SIGNATURE: _____

YOU MUST RETURN THIS FORM TO THE MINEOLA OFFICE WITH A COPY OF AN ITEMIZED BILL FROM YOUR NON-PARTICIPATING VISION PROVIDER AND PROOF OF PAYMENT.

A VISION BENEFIT APPLICATION MUST BE FILED NO LATER THAN **180 DAYS** FROM THE DATE OF SERVICE.