



LOCAL 273

RETURN COMPLETED STATEMENT TO

UFFA WELFARE FUND

P. O. BOX 994
NEW ROCHELLE, N. Y. 10802



LOCAL 273

No 10137

Optical Benefit

Members Statement (Print or Type)

NAME	DEPENDENT'S NAME If claim is on dependent)	AGE
ADDRESS	RELATIONSHIP	
ZIP	PHONE NO.	

If claim is for dependent child, is dependent 19 or older? YES NO

If dependent child is 19 or older, is dependent a full time college student and fully dependent upon you for support?
 YES NO

Name of College _____ State _____ Date of Graduation _____

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT

Date _____ Member's Signature _____

Active Retired

Optometrist — Optician — Physician Statement

PATIENT'S NAME	AGE		
OPHTHALMOLOGIST or OPTOMETRIST (circle one) (Describe fully, type and nature of examination)			
OPHTHALMOLOGIST OR OPTOMETRIST CHARGE FOR EXAMINATION \$ _____			
OPHTHALMOLOGIST (Please fill in and sign below)			
Date of Service	Doctor's Name	Doctor's Signature	Degree
Street Address	City or Town	State	Zip Phone No.

MATERIALS: STATEMENT

LENSES	OD	OS	CHARGE
SINGLE VISION	<input type="checkbox"/>	<input type="checkbox"/>	_____
BI-FOCAL	<input type="checkbox"/>	<input type="checkbox"/>	_____
TRI-FOCAL	<input type="checkbox"/>	<input type="checkbox"/>	_____
			Total Charge \$ _____
OPTOMETRIST OR OPTICIAN (Please fill in and sign below)			
Date of Service	Name (Print)	Signature	Degree
Street Address	City or Town	State	Zip Phone No.

This claim will not be honored unless signed by both member and optometrist, physician or optician. Paid in full receipt(s) must be submitted with this claim for the member to receive payment, if not, payment will be sent directly to the doctor(s).