CLAIM FORM FOR OPTICAL BENEFITS

WHEN COMPLETE
RETURN FORM TO:

AGVA WELFARE TRUST FUND
363 Seventh Avenue – 17th Floor
New York, New York 10001-3904
(212) 627-4820

PERFORMER'S STATEMENT
(please print)

LAST, FIRST, MI _____ S.S. # ___-___-____

MAILING ADDRESS _____

Male ___ Female ___ DATE OF BIRTH –(MM-DD-YYYY) ___-___-____

PAID RECEIPTS FOR ALL SERVICES MUST BE ATTACHED. ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY AND/OR FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

CERTIFICATE of OPTOMETRIST or OPHTHALMOLOGIST or OPTICIAN RENDERING SERVICES

I certify the above named patient was furnished the following services on the date(s) for which payment was received as indicated.

DATE OF EXAMINATION	PAYMENT RECEIVED
	$
LENSES	
	$
FRAMES	
	$
TOTAL RECEIVED:	$

Signature of Optometrist, Ophthalmologist or Optician (circle which on applies):

_____ DATE: _____ EMP. ID #_____

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Performer is eligible for $200.00 for Plan A Coverage and $55.00 for Plan B Coverage, only once in each calendar year, for Examination, Lenses and/or Frames if expenses are incurred while the performer is ELIGIBLE for non-job related benefits in accordance with the eligibility rules of the AGVA Welfare Trust Fund Plan of benefits.

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TO BE COMPLETED BY WELFARE FUND OFFICE

DATE RECEIVED	ELIGIBILITY	CLAIM NO.	CHECK NO.	DATE	PAYMENT	COMMENTS