

PART 1 – EMPLOYEE COMPLETES IN ALL CASES

EMPLOYEE'S NAME (PRINT) _____

PRESENT ADDRESS _____

(number and street)

(city)

(state)

(zip)

EMPLOYEES

SOCIAL SECURITY NO. - -

BIRTHDATE _____

MARITAL STATUS _____

(M S D W)

IS ANY DEPENDENT UNDER THIS PLAN EMPLOYED YES NO

DO YOU OR YOUR COVERED DEPENDENTS HAVE OTHER GROUP HEALTH COVERAGE? YES NO
IF YES, PLEASE IDENTIFY: SPOUSE EMPLOYEE CHILD

OTHER HEALTH COVERAGE

NAME _____

DATE OF BIRTH _____

NAME _____

SOC. SEC. NO. OF PERSON WITH OTHER COVERAGE

- -

POLICY NO./
I.D. NO. _____

ADDRESS _____

EFF. DATE _____

DOES OTHER GROUP COVERAGE LISTED ABOVE HAVE VISION BENEFITS? YES NO

I HEREBY AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. A COPY OR PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL. I ALSO CERTIFY THAT THE STATEMENTS MADE ARE TRUE, ACCURATE, AND COMPLETED TO THE BEST OF MY ABILITY; AND IF THE CLAIM IS FOR A DEPENDENT, THE DEPENDENT MEETS THE ELIGIBILITY REQUIREMENTS AS OUTLINED IN THE SUMMARY PLAN DESCRIPTION.

EMPLOYEE'S SIGNATURE _____

MUST BE SIGNED

DATE THIS CLAIM FORM SIGNED _____

PART 2 – COMPLETE THIS SECTION IF CLAIM IS FOR YOUR DEPENDENT

DEPENDENT'S FULL NAME _____ FULL TIME STUDENT? YES NO DATE OF BIRTH _____ SINGLE
RELATIONSHIP _____ MARRIED

PART 3 – TO BE COMPLETED BY DOCTOR MAKING EXAMINATION

FULL NAME OF PATIENT _____ DATE OF EXAM _____ CHARGE FOR EXAM \$ _____

DOCTOR'S NAME _____ GLASSES PRESCRIBED? YES NO

ADDRESS _____ TAXPAYER I.D. NUMBER _____
(Must be furnished under authority of law)

TELEPHONE _____

DOCTOR'S SIGNATURE _____ DEGREE _____

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DOCTOR _____
EMPLOYEE SIGNATURE

PART 4 – TO BE COMPLETED BY SUPPLIER OF GLASSES

FULL NAME OF PATIENT _____

NAME OF OPTICAL ORGANIZATION _____

ADDRESS _____

SUPPLIER'S SIGNATURE _____

TAXPAYER I.D. NUMBER _____ (Must be furnished under authority of law)

	AMOUNT CHARGED	✓ NEEDED BOX(ES)		
		BOTH	LEFT	RIGHT
SINGLE VISION RX	\$			
BI - FOCAL RX	\$			
TRI - FOCAL RX	\$			
CONTACTS	\$			
LENTICULAR	\$			
FRAMES	\$			

PURCHASE DATE _____

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED SUPPLIER. _____
EMPLOYEE SIGNATURE