

SELF INSURED PLANS, LLC

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EMPLOYER NAME _____

VISION CARE CLAIM FORM

PART A — TO BE COMPLETED BY EMPLOYEE					
1	GROUP POLICY NO. <small>COPY FROM YOUR I.D. CARD</small>	EMPLOYER			BRANCH OR DIVISION
2	NAME OF EMPLOYEE	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE SOCIAL SECURITY NO.
3	ADDRESS OF EMPLOYEE, NO. STREET		CITY	STATE	ZIP
4	TELEPHONE NO.	DATE YOU LAST WORKED	HAS YOUR EMPLOYMENT BEEN TERMINATED? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHEN?
5	IF MARRIED, YOUR SPOUSE'S FIRST NAME IS SPOUSE EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	SPOUSE'S DATE OF BIRTH	NAME AND ADDRESS OF SPOUSE'S EMPLOYER		
6	COMPLETE LINES 6 & 7 FOR DEPENDENT CLAIMS ONLY	NAME OF DEPENDENT/ PATIENT	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	SEX <input type="checkbox"/> M <input type="checkbox"/> F
7		EMPLOYER (IF ANY) OF DEPENDENT/PATIENT			BIRTHDATE RELATIONSHIP ADDRESS OF DEPENDENT/PATIENT
8	HAVE YOU (OR YOUR DEPENDENT) VISITED A DOCTOR OR TAKEN PRESCRIPTION MEDICINE FOR THIS CONDITION BEFORE DATES SHOWN BY YOUR DOCTOR ON THIS FORM? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, NAME AND ADDRESS OF DOCTOR		DATE OF TREATMENT
9	DO YOU HAVE ANY FAMILY MEMBERS HAVE ANY OTHER BENEFIT PLAN FOR THE EXPENSES SUBMITTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES (A) INSURANCE CO. (B) EMPLOYER (C) POLICY NO. OR I.D. NO.		
10	IS CONDITION DUE TO ACCIDENTAL INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES WAS THE INJURY CAUSED BY THE ACT OR OMISSION OF A PERSON OTHER THAN YOURSELF? <input type="checkbox"/> YES <input type="checkbox"/> NO	PLACE OF ACCIDENT <input type="checkbox"/> AUTO <input type="checkbox"/> WORK <input type="checkbox"/> HOME <input type="checkbox"/> OTHER		DATE OF ACCIDENT
AUTHORIZATION: I HEREBY AUTHORIZE RELEASE TO OR BY SELF INSURED PLANS LLC OF ANY HOSPITAL, MEDICAL, OR OTHER BENEFIT INFORMATION CONCERNING MYSELF OR ANY OF MY DEPENDENTS WHICH MAY BE REQUIRED TO PROCESS MY CLAIM A PHOTOCOPY OF THE AUTHORIZATION MY BE HONORED.				EMPLOYEE'S SIGNATURE _____ DATE SIGNED _____	

HOW TO FILE YOUR CLAIM

IMPORTANT NOTICE TO EMPLOYEE — READ CAREFULLY

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claims containing any false, incomplete or misleading information may be subject to criminal penalties.

Have your doctor and optician complete Part B on the back of claim form and return it to you.

Attach an itemized bill for any charges not shown on the form. **DO NOT SEND CANCELLED CHECKS, CASH REGISTER RECEIPTS OR LISTS PREPARED BY THE CLAIMANT. THE ACTUAL BILLS ARE NEEDED.** If you wish to assign benefits please sign where indicated on the reverse side.

PART B
STATEMENT OF VISION CARE
Examination and Materials

TO BE COMPLETED BY EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST

Patient's Name _____
 Nature of disease, injury or vision disorder, if any _____
 Did this disorder arise out of patient's employment? YES NO
 IF YES, EXPLAIN _____

SERVICES PROVIDED
 Eye Examination, Including Refraction \$ _____ Eye Examination Without Refraction \$ _____
 Other (describe) _____ \$ _____

PRESCRIPTION

	Sphere	Cylinder	Axis	Prism	Add for Reading
Right					
Left					

Did patient have eyeglasses prior to date of your examination? YES NO
 If Yes, is prescription for new lenses different from that of lenses being replaced? YES NO

DATES OF EXAMINATIONS _____

I am a legally qualified OPTHALMOLOGIST OPTOMETRIST

SIGNED _____ DATE _____
 NAME (Please Print) _____ TIN# _____
 ADDRESS _____ PHONE _____

TO BE COMPLETED BY PROVIDER OF MATERIALS
 An itemized bill for lenses and frames may be submitted in place of this statement

MATERIALS PROVIDED Lenses for One Eye Both Eyes

Single Vision \$ _____ Bifocal \$ _____ Trifocal \$ _____ Lenticular \$ _____ Sunglasses \$ _____ Other \$ _____
 If contact lenses prescribed, give reason _____

Frames \$ _____ Are existing frames being used for new lenses? YES NO
 Date of Purchase _____

I am a legally qualified OPTHALMOLOGIST OPTOMETRIST OPTICIAN

*SIGNED _____ DATE _____
 NAME (Please Print) _____ TIN# _____
 ADDRESS _____ PHONE _____

*If examining doctor provides glasses, only one signature is necessary

PLEASE RETURN FORM TO PATIENT

OPTIONAL ASSIGNMENT OF BENEFITS APPLIES TO CHARGES OF

DOCTOR
 OPTICAL CO.
 (PLEASE INDICATE)

I hereby authorize SELF INSURED PLANS LLC to pay directly to the provider(s) of services
 I have indicated the benefits for their charges otherwise payable to me

 EMPLOYEE'S SIGNATURE

 DATE