

**TO BE COMPLETED BY EMPLOYEE**

1	NAME OF EMPLOYEE	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	SEX BIRTHDATE	PHONE NO
2	ADDRESS OF EMPLOYEE	NUMBER AND STREET	CITY	STATE ZIP CODE
3	POLICY NO.	S.S. #	EMPLOYER	DATE EMPLOYED HAS YOUR EMPLOYMENT TERMINATED <input type="checkbox"/> YES <input type="checkbox"/> NO
4	NAME OF CLAIMANT	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	SEX <input type="checkbox"/> M <input type="checkbox"/> F BIRTHDATE	RELATIONSHIP

**FAILURE TO ANSWER ALL QUESTIONS PROPERLY WILL CAUSE DELAY**

5	IF MARRIED, YOUR SPOUSE'S FIRST NAME _____ SPOUSE'S SOCIAL SECURITY NUMBER _____ IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME AND ADDRESS OF SPOUSE'S EMPLOYER
6	DOES THE PERSON FOR WHOM THIS CLAIM IS BEING MADE HAVE ANY OTHER GROUP INSURANCE OR PRIVATE MEDICAL PLAN COVERAGE FOR VISION CARE EXPENSES? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE COMPLETE THE FOLLOWING: A. NAME OF EMPLOYER _____ B. NAME OF INSURANCE COMPANY _____ C. ADDRESS OF INSURANCE CO. _____ D. POLICY NUMBER _____ E. CERTIFICATE NUMBER _____ F. UNION LOCAL NUMBER _____
7	<b>ASSIGNMENT:</b> I AUTHORIZE BENEFIT PAYMENT DIRECTLY TO THE PROVIDER OF SERVICE. INSURED'S SIGNATURE _____	DATE _____

**TO BE COMPLETED BY THE DOCTOR OR PROVIDER OF SERVICE**

DATE SERVICE BEGAN _____	DATE SERVICE COMPLETED _____	INCLUDING TONOMETRY <input type="checkbox"/> YES <input type="checkbox"/> NO	INCLUDING REFRACTION <input type="checkbox"/> YES <input type="checkbox"/> NO	EXAMINATION	\$
IS THIS A REPLACEMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF "YES," PLEASE GIVE REASON FOR REPLACEMENT _____			FRAMES	\$
PRINT OR TYPE DOCTOR'S OR PROVIDER'S NAME _____		ONE <input type="checkbox"/> TWO <input type="checkbox"/>	ONE <input type="checkbox"/> TWO <input type="checkbox"/>	LENSES - SINGLE VISION	\$
DOCTOR'S OR PROVIDER'S ADDRESS _____		ONE <input type="checkbox"/> TWO <input type="checkbox"/>	ONE <input type="checkbox"/> TWO <input type="checkbox"/>	LENSES - BIFOCAL	\$
CITY - STATE - ZIP CODE _____		ONE <input type="checkbox"/> TWO <input type="checkbox"/>	ONE <input type="checkbox"/> TWO <input type="checkbox"/>	LENSES - TRIFOCAL	\$
DOCTOR'S OR PROVIDER'S SIGNATURE _____		ONE <input type="checkbox"/> TWO <input type="checkbox"/>	ONE <input type="checkbox"/> TWO <input type="checkbox"/>	LENSES - CONTACT	\$
		ONE <input type="checkbox"/> TWO <input type="checkbox"/>	ONE <input type="checkbox"/> TWO <input type="checkbox"/>	LENSES - LENTICULAR	\$
				TOTAL CHARGES	\$
		DEGREE _____	TELEPHONE NUMBER _____		
		DATE _____			

MUST BE FURNISHED UNDER AUTHORITY OF LAW

INDIVIDUAL PRACTITIONERS - SS #			
ALL OTHERS - EMPLOYER I.D. #			