COMPLETE AND RETURN TO:
FITZHARRIS & COMPANY, INC.
Claim & Administration Service Center
P.O. BOX 9182
FARMINGDALE, NY 11735-9182
(516) 777-2244

VISION CARE Statement of Claim

PART 1 EMPLOYER/PLAN ADMINISTRATOR

INSURED	EMPLOYEE ID NUMBER (If applicable)	GROUP NAME	POLICY NO.

DATE BENEFITS BECAME EFFECTIVE Mo Day Year Mo Day Year EMP. DEP.	DATE TERMINATED Mo Day Year	SIGNATURE OF AUTHORIZED PERSON	DATE

PART 2 TO BE COMPLETED BY INSURED

1. PATIENT NAME	2. RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER	3. SEX M F	4. PATIENT BIRTHDATE MO DAY YEAR	5. IF FULL TIME STUDENT SCHOOL CITY

6. INSURED NAME FIRST NAME MIDDLE LAST	7. EMPLOYEE SOCIAL SECURITY NO.	9. EMPLOYER
8. MAILING ADDRESS	10. ARE OTHER FAMILY MEMBERS EMPLOYED? ☐ YES ☐ NO If Yes, indicate NAME SOC. SEC. NO.	
CITY, STATE, ZIP	11. NAME AND ADDRESS OF EMPLOYER IN ITEM 10	

12. IS PATIENT COVERED BY ANOTHER PLAN? ☐ YES ☐ NO	PLAN NAME	UNION LOCAL	GROUP NO.	NAME AND ADDRESS OF CARRIER

I authorize any individual or organization to release any information to First Rehabilitation Life Insurance Company of America for any services or benefits received or payable to me or on my behalf.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information , or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of Eligible Insured ______________________________ Date__________

I authorize payment of vision benefits to undersigned physician or supplier for service described below.

Signature of Insured ______________________________ Date__________

PART 3 TO BE COMPLETED BY OPTOMETRIST OR OPHTHALMOLOGIST

1. OPTOMETRIST/OPHTHALMOLOGIST	7. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO YES IF YES, ENTER BRIEF DESCRIPTION AND DATES
2. MAILING ADDRESS	8. IS TREATMENT RESULT OF AUTO ACCIDENT?
3. CITY, STATE, ZIP	9. OTHER ACCIDENT?
4. SOC. SEC. OR T.I.N. 5. LICENSE NO. 6. PHONE NO.	10. ARE ANY SERVICES COVERED BY ANOTHER PLAN?

11. DESCRIPTION OF SERVICES	DATE OF SERVICE	FEE
A. EXAMINATION		
B. SINGLE VISION WITH FRAME		
C. BIFOCAL WITH FRAME		
D. FRAME ONLY		

11. DESCRIPTION OF SERVICES	DATE OF SERVICE	FEE
E. LENSES ONLY 1) SINGLE VISION		
2) BIFOCAL		
F. CONTACT LENSES		
G. OTHER		
H. TOTAL CHARGES		

12. PLEASE COMPLETE THE FOLLOWING:

A. WERE LENSES PRESCRIBED AS A RESULT OF EYE SURGERY? YES_______ NO _______

IF "YES" PLEASE SPECIFY PROCEDURE:______________________________

B. WHAT IS PATIENT'S PRESENT DEGREE OF VISUAL ACUITY?

CORRECTED__________ UNCORRECTED __________

C. IF TINTED GLASSES WERE FURNISHED, WERE THEY SPECIFICALLY PRESCRIBED FOR MEDICAL REASONS?

YES__________ NO__________

D. PLEASE SIGN BELOW

____
SIGNATURE DATE

GVC1 (a) XGMM (Rev. 9-98)