



Group Marketing Services, Inc.

P.O. Box 19040
Kalamazoo, Michigan 49019-0040

Assurity Life Insurance Company Vision Care Benefit Claim Form

TO BE COMPLETED BY EMPLOYEE: (Please Print)

_____|_____|_____| [] Male
Social Security Number [] Female

_____|_____|_____|
Last name First Middle

Home address

_____|_____|_____|
City - State - Zip

Date of birth

Name of Employer

Date employed

I hereby certify that the above and attached information is correct and hereby authorize my employer, Assurity Life Insurance Company, or other companies or organizations providing benefits or services for medical treatment or supplies to release or obtain any information necessary to determine the benefits payable under the plan of group insurance issued by Assurity Life Insurance Company

Employee Signature _____ Date _____

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

Employee Signature _____ Date _____

ATTENTION EMPLOYEE: Please attach bill or receipt for services. If you did not have a new eye exam, please indicate the date of your last eye exam.

COMPLETE ONLY IF A DEPENDENT CLAIM	
[] Male	
[] Female	
_____ Full name of dependent	
_____ Date of birth	_____ Relationship

Are you eligible for visual care benefits from any other source?

[] No
[] Yes
Other policy number _____ Name of other insurance company or plan _____

Address of other insurance company's claims settlement office

TO BE COMPLETED BY THE PHYSICIAN OR SUPPLIER OF SERVICE:

Indicate nature of disease, injury, or eye disorder:

Including tonometry [] Yes [] No
Including refraction [] Yes [] No
Is this a replacement? [] Yes [] No
If "Yes", please give reason for replacement: _____

If contact lenses prescribed:
(A) Due to severe corneal astigmatism, severe corneal scarring, keratoconus, or achakia? [] Yes [] No
(B) If yes, will sight be improved to at least 20/70 with contact lenses? [] Yes [] No
(C) If yes, could that level be attained with spectacle lenses? [] Yes [] No

Print or type physician's or supplier's name

Physician's or supplier's address

_____|_____|_____|
City - State - Zip

Physician's or supplier's signature Degree

Telephone number: (_____) _____

Date Of Service/Delivery		Administrative Use Only
_____	\$ _____ Examination	
_____	\$ _____ Frames	
_____	One Two \$ _____ <input type="checkbox"/> <input type="checkbox"/> Lenses - single vision	
_____	One Two \$ _____ <input type="checkbox"/> <input type="checkbox"/> Lenses - bifocal	
_____	One Two \$ _____ <input type="checkbox"/> <input type="checkbox"/> Lenses - trifocal	
_____	One Two \$ _____ <input type="checkbox"/> <input type="checkbox"/> Lenses - contact	
_____	One Two \$ _____ <input type="checkbox"/> <input type="checkbox"/> Lenses - lenticular	
Total Charges \$ _____		

Date

MUST BE FURNISHED UNDER AUTHORITY OF LAW:

Individual Practitioners -- Social Security No. _____

All others -- Employer I.D. Number _____