



Group Marketing Services, Inc.

P.O. Box 19040
Kalamazoo, MI 49019
(616) 343-2611

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

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

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 mot 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 _____ | _____