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?

☐ No
☐ Yes

Name of Employer

Date employed

Other policy number Name of other insurance company or plan

Address of other insurance company's claims settlement office

COMPLETE ONLY IF A DEPENDENT CLAIM
☐ Male
☐ Female

Full name of dependent

Date of birth Relationship

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.

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	$_____ | _____
	□ □	Lenses- single vision
_____	One Two	$_____ | _____
	□ □	Lenses-bifocal
_____	One Two	$_____ | _____
	□ □	Lenses-trifocal
_____	One Two	$_____ | _____
	□ □	Lenses- contact
_____	One Two	$_____ | _____
	□ □	Lenses- lenticular
	Total Charges	$_____ | _____

_____
Date

MUST BE FURNISHED UNDER AUTHORITY OF LAW:

Individual Practitioners – Social Security No. _____ | _____ | _____
All others – Employer I.D. Number _____ | _____