

KLAIS & COMPANY, INC.

EMPLOYEE BENEFIT CONSULTANTS AND ADMINISTRATORS

1867 WEST MARKET STREET

AKRON, OHIO 44313-6977

(330) 867-8443

STATEMENT OF CLAIM FOR GROUP VISION BENEFITS

TO BE COMPLETED BY EMPLOYEE

1. Employer _____ City _____ State _____ Group # _____

2. Employee Name _____ Date of Birth _____

3. Home Address _____
Number _____ Street _____ City _____ State _____ Zip _____

4. Marital Status: Single Married Divorced Widowed Social Security Number _____ - _____ - _____

5. Telephone No. (____) _____

6. Is this claim for a dependent? Yes No If yes, give name _____

Relationship _____ Date of Birth _____ / _____ / _____ Married Yes No Full-time Student Yes No

Name & Address of University _____

7. Are you: Active Employee

Retired: Date Retired _____

Cobra Participant

8. Is your spouse employed? Yes No If yes, give name of spouse _____

Name of spouse's Employer _____ Phone No. (____) _____

Employer's Address _____

9. Is patient covered for benefits by any other: YES NO

A. Group Vision Benefits of any kind thru an Employer, Union, Welfare Plan or a School? YES NO

B. Coverage of vision care expenses provided thru any Federal, State, Provincial or other
Governmental Agency? YES NO

C. Coverage of vision care expenses provided thru any HMO. YES NO

If any of the above are answered yes, please complete the following:

Other Employer _____ Other Insurance Co. or Benefits Plan _____

Address _____ Address _____

Telephone No. (____) _____ Telephone No. (____) _____ Policy No. _____

If Blue Cross show Group and Cert. No. from Blue Cross ID Card _____
Group No. _____ Cert. No. _____

10. I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacist,
or Optician to release any information requested with respect to this claim.

**I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.
I certify that the information furnished by me in support of this claim is true and correct.**

Date _____ 20 ____ Signature of Employee _____

COMPLETE THIS SECTION ONLY IF YOU WISH THE BENEFITS TO GO DIRECTLY TO THE PROVIDER(S)

Authorization to Pay Benefits: I hereby authorize payment directly to: any physician or provider of service for which I am submitting attached billings and charges.

For the expenses provided under my Group Medical Expense Benefits, I understand I am financially responsible for charges not covered by this authorization.

Signature _____