



# Statement of Claim - Vision Care

GE Group Life Assurance Company  
Employer Services Group

Mail to: Group Vision Benefits  
P.O. Box 1477  
Greenfield, MA 01302-1477

## Part 1 - to be completed by Insured (complete and return to GE Group Life Assurance)

1. Patient Name	2. Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	3. Sex <input type="checkbox"/> M <input type="checkbox"/> F	4. Patient Birthdate (Mo, Day, Yr) / /	5. If Full Time Student (School/City)
6. Employee's Name (First, Middle, Last)			7. Employee Birthdate (MM,DD,YY) / /	8. Group Number
9. Mailing Address (Please include Street, Apt Number, City, State, and ZIP Code)			10. Employee Social Security No. - -	11. Spouse's Name
12. Employer's Name			13. Are Other Family Members Employed <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes" indicate Name and Social Security No.)	
14. Name and Address of Employer(s) in Item 13				
15. Is Patient Covered By Another Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No    Plan Name    Union Local    Group Number    Name and Address of Carrier				

TO: All providers of medical services and supplies, employers, insurance institutions and other organizations. I authorize release to GE Group Life Assurance, Claims Administrator, my employer or other representatives any information, including medical, employment and benefit information required for claim processing or plan administration. This authorization is valid for one year after the date signed. A copy of this authorization shall be as valid as the original. I understand I may request a copy of this authorization.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the provider named below on this claim for the group vision benefits otherwise payable to me, but not to exceed the charges shown. I understand that I am financially responsible for any charges not covered by this authorization.

Signature of Employee

Date

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 also 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 \_\_\_\_\_

## Part 2 - to be completed by Optometrist or Ophthalmologist or Supplier

1. Optometrist/Ophthalmologist or Supplier	2. Is Treatment Result of Auto Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	3. Other Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Mailing Address (Please include Street, Apt Number, City, State, and ZIP Code)		
5. Soc. Sec. No. or TIN	6. License No.	7. Phone No.
8. Is Treatment Result of Occupational Illness or Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", Enter Brief Description and Dates		9. Are Any Services Covered by Another Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
10. Description of Services	Date of Service	Fee
A. Examination		
B. Single Vision With Frame		
C. Bifocal With Frame		
D. Frame Only		
E. Tint		
F. Lenses Only - 1) Single Vision		
- 2) Bifocal		
G. Contact Lenses		
H. Other		
I. Total Charges		

### 11. 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. Indicate diagnosis or nature of disease or vision disorder \_\_\_\_\_

If tinted glasses were furnished, were they specifically prescribed for medical reasons?  Yes  No

D. Provider signature \_\_\_\_\_ Date \_\_\_\_\_

Mail Completed Form To: Group Vision Benefits  
PO Box 1477  
Greenfield, MA 01302-1477

(800) 451-2513