

RETURN COMPLETED FORM TO:  
3925 Fountains Blvd NE, Suite 104  
Cedar Rapids, IA 52411  
(319) 365-2810



**CLAIM FORM  
VISION CARE BENEFITS**

**EMPLOYEE INFORMATION - REQUIRED for all claims**

Name of Employee: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
(Last) (First) (Middle)

Date of Birth: \_\_\_\_\_

Employee's Marital Status: Single: \_\_\_\_\_ Married: \_\_\_\_\_ Widowed: \_\_\_\_\_ Divorced: \_\_\_\_\_ Separated: \_\_\_\_\_

Social Security No. \_\_\_\_\_ Occupation \_\_\_\_\_ Active  Retired

Street Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

**DEPENDENT INFORMATION - If Claim is For Your Dependent**

Name of Dependent: \_\_\_\_\_

Relationship to Employee: \_\_\_\_\_

Dependent's Marital Status: Single: \_\_\_\_\_ Married: \_\_\_\_\_ Widowed: \_\_\_\_\_ Divorced: \_\_\_\_\_ Separated: \_\_\_\_\_

Is Dependent Employed?  YES  NO

Is Dependent Attending School?  YES  NO

If YES:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State: \_\_\_\_\_  
Zip: \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State: \_\_\_\_\_  
Zip: \_\_\_\_\_

Do you or your dependents have any other health insurance?  YES  NO

If YES :

Relationship: \_\_\_\_\_  
Name of the person insured: \_\_\_\_\_  
Relationship to Employee: \_\_\_\_\_  
Insured person's employer: \_\_\_\_\_  
Employer's street address: \_\_\_\_\_  
City, State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Policy Number \_\_\_\_\_ Certificate number: \_\_\_\_\_  
SSN: \_\_\_\_\_ Phone number ( ) \_\_\_\_\_

**NOTE:** Attach copy of payment worksheet or denial from other insurance.

**[ ACCIDENT INFORMATION ]**

If this treatment was required due to accidental injury, please complete Accidental Information section on other side of this form

**[ AUTHORIZATION ]**

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release, when requested by the Trustees or their representative, of any facts concerning the treatment of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original.

Employee's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_