Mail completed vision claim form to:

P.O. Box 1527
Latham, NY 12110

Customer Service
1-800-300-9566

Security Life

INSURANCE COMPANY OF AMERICA

NOTE: PLEASE COMPLETE THIS FORM AS FULLY AS POSSIBLE. INCOMPLETE FORMS MAY DELAY PROCESSING OF YOUR CLAIM.

SECTION I - INSURED INFORMATION

NAME OF INSURED: LAST	FIRST	MIDDLE INITIAL	DATE OF BIRTH (MONTH / DAY / YEAR)

SOCIAL SECURITY NUMBER:	MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED	IS SPOUSE EMPLOYED? ❑ YES ❑ NO

HOME ADDRESS: STREET OR BOX NUMBER	CITY	STATE	ZIP CODE

NAME OF SPOUSE: LAST	FIRST	MI	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:

IF YES, NAME AND ADDRESS OF SPOUSE'S EMPLOYER:

SECTION II - PATIENT INFORMATION

NAME OF PATIENT: LAST	FIRST	MI	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:

PATIENT'S RELATIONSHIP TO EMPLOYEE ❑ SELF ❑ SPOUSE ❑ NATURAL CHILD ❑ STEP CHILD ❑ OTHER:_____	IF CHILD, IS HE/SHE A FULL-TIME STUDENT? ❑ YES ❑ NO

NAME AND ADDRESS OF SCHOOL

IS ILLNESS OR INJURY DUE TO PATIENT'S WORK? ❑ YES ❑ NO TO AN AUTOMOBILE ACCIDENT? ❑ YES ❑ NO TO OTHER ACCIDENT? ❑ YES ❑ NO

IF INJURY, DESCRIBE HOW, WHEN, AND WHERE ACCIDENT OCCURRED

PLACE:_____ TIME:_____ DATE OF INJURY:_____

POSSIBLE LEGAL ACTION? ❑ YES ❑ NO HOW:_____

OTHER INSURANCE FOR ACCIDENT? ❑ YES ❑ NO

SECTION III - OTHER INSURANCE INFORMATION

IS PATIENT COVERED BY OTHER VISION INSURANCE (I.E. MEDICARE, HMO, EMPLOYER GROUP PLAN, ETC.)? ❑ YES ❑ NO

IF YES, GIVE NAME OF PERSON COVERED BY INSURANCE:

NAME OF INSURANCE COMPANY:	POLICY, PLAN OR SOCIAL SECURITY NO.

ADDRESS OF INSURANCE COMPANY (STREET / CITY / STATE / ZIP CODE):

SECTION IV - AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I certify that the above statements are correct and hereby authorize any health care provider, employer, union, HMO or insurance company to supply Security Life Insurance Company, its agents, or any agent of the Employer any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

EMPLOYEE'S SIGNATURE: DATE:

I HEREBY AUTHORIZE THAT PAYMENT BE MADE DIRECTLY TO THE PROVIDER OF SERVICES.

EMPLOYEE'S SIGNATURE: DATE:

Indicate diagnosis or nature of disease or injury or vision disorder

PRESCRIPTION	SPHERE	CYLINDER	AXIS	PRISM	ADD FOR READING
RIGHT					
LEFT					

DID PATIENT HAVE EYEGLASSES PRIOR TO THE DATE OF YOUR EXAMINATION?
❑ YES ❑ NO

IF "YES" IS PRESCRIPTION FOR NEW LENSES DIFFERENT FROM THAT OF LENSES BEING REPLACED? ❑ YES ❑ NO

Describe and indicate additional charges for special features such as hardening, tinting, lenses in excess on 54 millimeters, etc.

Are existing frames being used for the new lenses? ❑ YES ❑ NO

If "no", why? _____

DATE OF SERVICE				PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances)			DIAGNOSIS CODE	CHARGES
MM	DD	YY	Place of Service	Type of Service	CPT/HCPCS	MODIFIER		

Physician's or Optometrist's Name, Address & Zip Code
❑ Opthalmologist
❑ Optometrist
❑ Optician

Total Charge

Telephone No:

Your Social Security No:

Signature of Physician or Optometrist

Date Signed

Your Employee I.D. No:

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