the first REHABILITATION LIFE INSURANCE COMPANY of AMERICA

J. J. Stanis and Company, Inc.

100 Jericho Quadrangle
Suite 101
Jericho, NY 11753

VISION CARE

Statement of Claim

To access additional forms, please visit our website at www.jjstanisco.com

PART 1 EMPLOYER/PLAN ADMINISTRATOR

INSURED	EMPLOYEE ID NUMBER (If applicable)	GROUP NAME	POLICY NO.

DATE BENEFITS BECAME EFFECTIVE Mo Day Year Mo Day Year EMP. DEP.	DATE TERMINATED Mo Day Year	SIGNATURE OF AUTHORIZED PERSON	DATE

PART 2 TO BE COMPLETED BY INSURED

1. PATIENT NAME	2. RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER	3. SEX M F	4. PATIENT BIRTHDATE MO DAY YEAR	5. IF FULL TIME STUDENT SCHOOL CITY

6. INSURED NAME FIRST NAME MIDDLE LAST	7. EMPLOYEE SOCIAL SECURITY NO.	9. EMPLOYER

8. MAILING ADDRESS	10. ARE OTHER MEMBERS EMPLOYED ? ☐ YES ☐ NO NAME SOC. SEC. NO. If Yes, Indicate

CITY, STATE, ZIP	11. NAME AND ADDRESS OF EMPLOYER IN ITEM 10

12. IS PATIENT COVERED BY ANOTHER PLAN ? ☐ YES ☐ NO PLAN NAME UNION LOCAL	GROUP NO. NAME AND ADDRESS OF CARRIER

I authorize any individual or organization to release any information to First Rehabilitation Life Insurance company of America for any services or benefits received or payable to me or on my behalf.

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 be subject to a civil penalty not to exceed five thousand dollars and stated value of the claim for each such violation.

Signature of Eligible Insured _____ Date _____

I authorize payment of vision benefits to the undersigned physician or supplier for service described below.

Signature of Insured _____ Date _____

PART 3 TO BE COMPLETED BY OPTOMETRIST OR OPHTHALMOLOGIST

1. OPTOMETRIST/OPTHALMOLOGIST	7. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY ? No Yes IF YES, ENTER BRIEF DESCRIPTION AND DATES

2. MAILING ADDRESS	8. IS TREATMENT RESULT OF AUTO ACCIDENT ?

3. CITY, STATE, ZIP	9. OTHER ACCIDENT ?

4. SOC.SEC. OR T.I.N. 5. LICENSE NO. 6. PHONE NO.	10. ARE ANY SERVICES COVERED BY ANOTHER PLAN ?

11. DESCRIPTION OF SERVICES	DATE OF SERVICE	FEE
A. EXAMINATION		
B. SINGLE VISION WITH FRAME		
C. BIFOCAL WITH FRAME		
D. FRAME ONLY		

11. DESCRIPTION OF SERVICES	DATE OF SERVICE	FEE
E. LENSES ONLY 1) SINGLE VISION		
2) BIFOCAL		
F. CONTACT LENSES		
G. OTHER		
H. TOTAL CHARGES		

12. 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. IF TINTED GLASSES WERE FURNISHED, WERE THEY SPECIFICALLY PRESCRIBED FOR MEDICAL REASONS?

YES _____ NO _____

D. PLEASE SIGN BELOW

_____
SIGNATURE **DATE**