EYE CARE
GROUP CLAIM FORM

Group Claim Office / P.O. Box 82510, Lincoln, NE 68501
Toll Free No.: 800-497-7044 / Fax: 402-467-7336

RELIANCE STANDARD
Life Insurance Company
a DELPHI company

PLEASE BE AS COMPLETE AND ACCURATE AS POSSIBLE WHEN COMPLETING THIS CLAIM FORM.
ERRORS OR OMISSIONS MAY DELAY CLAIM PAYMENTS.

PART A - TO BE COMPLETED BY INSURED

1. PATIENT'S NAME *(Last, First, Middle)*	2. PATIENT'S BIRTHDATE	3. PATIENT'S SEX ❑ M ❑ F	4. RELATIONSHIP TO INSURED ❑ Self ❑ Spouse ❑ Child ❑ Other

5. INSURED'S NAME *(Last, First, Middle)*	6. INSURED'S SOCIAL SECURITY NO.	7. INSURED'S BIRTHDATE

8. INSURED'S STREET ADDRESS	9. NAME OF EMPLOYER / GROUP NUMBER
	136-413210

10. CITY, STATE, ZIP CODE

11. IS PATIENT COVERED FOR EYE CARE BY ANOTHER PLAN? ❑ Yes ❑ No **If YES, please complete boxes 12 through 16.**	12. NAME AND ADDRESS OF OTHER CARRIER

13. INSURED'S NAME	14. RELATIONSHIP TO INSURED ❑ Self ❑ Spouse ❑ Child ❑ Other	15. INSURED'S BIRTHDATE	16. INSURED'S SSN / GROUP NUMBER

17. THIS SECTION MUST BE COMPLETED WITH *EACH* CLAIM SUBMISSION *ONLY* IF THE CLAIM IS FOR A DEPENDENT CHILD AGE 19 OR OVER.

Is patient a full-time student? ❑ Yes ❑ No. If YES, Name and Address of School _____

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION TO RELIANCE STANDARD ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I CERTIFY THAT THE ABOVE INFORMATION BY ME IN SUPPORT OF THIS CLAIM IS COMPLETE AND CORRECT AND THAT I AM CLAIMING BENEFITS ONLY FOR CHARGES INCURRED BY THE ABOVE NAMED PATIENT.

SIGNATURE OF INSURED _____ DATE _____

It is fraudulent to fill out this form with information you know to be false or to knowingly omit facts which may have a bearing on the benefits for which you are applying. Criminal and/or civil penalties can result from such acts.

PART B - TO BE COMPLETED BY DOCTOR

1. DOCTOR'S NAME *(Last, First, Middle)*	2. TITLE ❑ D.O. ❑ M.D. ❑ O.D.

3. DOCTOR'S STREET ADDRESS	4. CITY, STATE, ZIP CODE

5. PHONE ( )	6. WERE EYEGLASSES PRESCRIBED? ❑ YES ❑ NO WERE CONTACTS PRESCRIBED? ❑ YES ❑ NO	7. HAS CATARACT SURGERY BEEN PERFORMED? ❑ YES ❑ NO	**8. EXAMINATION DATE** PLEASE ENTER EXAMINATION CHARGE IN FEE COLUMN BELOW (BLOCK 12.)

9. ASSIGNMENT CANNOT BE MADE WITHOUT TAX I.D. NUMBER.	10. I HEREBY CERTIFY THAT I HAVE PERFORMED THE SERVICES AS INDICATED HEREON.
Doctor's Tax I.D. # _____	DOCTOR'S SIGNATURE _____ DATE _____

11. DIAGNOSIS OR NATURE OF OFFICE VISIT

PART C - TO BE COMPLETED BY DOCTOR/DISPENSER

CHECK APPROPRIATE BOX

FRAME	SIZE & MODEL					MFG.			ZYL	METAL	RIMLESS	COMBO
LENSES	# OF LENSES	GLASS	PLASTIC		SV	BIF	TRI	PAL	SAFETY	OTHER		
LENS OPTIONS	OS	TINT	GRAD	DBL GRAD	COAT	UV400	FACET	PHOTO CHROMIC	OTHER			
CONTACT LENSES	# OF LENSES	HCL	SCL	HGP	DISPOS-ABLE	SPH	BIF	TORIC	EW	TINT	NUMBER REPLACED	OTHER

DATE ORDERED	DATE DISPENSED	OTHER SERVICES

DISPENSING OFFICE PHONE ( )

ADDRESS STREET CITY STATE ZIP

ASSIGNMENT CANNOT BE MADE WITHOUT TAX I.D. NUMBER. Dispensers Tax I.D. Number_____

I HEREBY CERTIFY THAT I HAVE PERFORMED THE SERVICES AS INDICATED HEREON.

DISPENSER'S SIGNATURE _____ DATE _____

12.	AMOUNT
EXAMINATION CHARGE	
FRAME CHARGE	
LENS CHARGE	
OPTIONS CHARGE	
CONTACT CHARGE	
OTHER SERVICES	
SUBTOTAL	
SALES TAX (If Applicable)	
TOTAL CHARGES	
AMOUNT PAID BY PATIENT	