



342 INSURANCE TRUST CLAIM FOR VISION BENEFITS EMPLOYEE'S STATEMENT

Please return this form to:
342 INSURANCE TRUST
 501 William Floyd Parkway
 Shirley, N.Y. 11967-3417
 Tel. 631-395-1700
 Fax: 631-395-1943

SECTIONS A & E MUST BE COMPLETED

SECTIONS B & D MUST BE COMPLETED IF PATIENT IS OTHER THAN THE EMPLOYEE

IT IS A CRIME TO COMPLETE THIS FORM WITH INFORMATION YOU KNOW IS FALSE, INCORRECT, OR TO LEAVE OUT FACTS THAT YOU KNOW ARE IMPORTANT TO THIS CLAIM.

EMPLOYEE'S NAME: FIRST		MIDDLE INITIAL	LAST	DATE OF BIRTH MONTH DAY YEAR	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
EMPLOYEE'S ADDRESS: STREET AND NO.		CITY	STATE	ZIP	
IS THIS A NEW ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS THIS A TEMPORARY ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO	EMPLOYEE'S I.D./SOCIAL SECURITY NO. CLAIM CANNOT BE PROCESSED WITHOUT THIS NUMBER ▶		[][]-[][]-[][][][]	
MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		IS CLAIM THE RESULT OF AN ACCIDENT OR OCCUPATIONAL ILLNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES" COMPLETE SECTION BELOW.		ARE YOU (EMPLOYEE) COVERED BY ANOTHER GROUP BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES" COMPLETE SECTION D BELOW.	

PATIENT'S INFORMATION — Complete only if patient is other than employee

PATIENT'S NAME: FIRST		MIDDLE INITIAL	LAST	RELATIONSHIP TO EMPLOYEE SPOUSE CHILD OTHER-SPECIFY	DATE OF BIRTH MONTH DAY YEAR	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
COMPLETE THIS INFORMATION IF PATIENT IS AN UNMARRIED DEPENDENT CHILD AGE 19 AND OLDER *	DEPENDENT CHILD IS <input type="checkbox"/> EMPLOYED FULL-TIME <input type="checkbox"/> STUDENT FULL-TIME	NAME OF CHILD'S SCHOOL/EMPLOYER-STREET ADDRESS		CITY	STATE	ZIP
FULL-TIME STUDENTS UNDER AGE TWENTY-THREE (23) MUST SUBMIT PROOF OF STUDENT STATUS EACH SEMESTER.						

ACCIDENT/OCCUPATIONAL CLAIM INFORMATION — Complete only if claim is a result of an accident or occupational illness/injury

IS CLAIM DUE TO AN ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF ACCIDENT MONTH DAY YEAR	DESCRIPTION OF ACCIDENT (HOW & WHERE)
DESCRIBE OCCUPATIONAL ILLNESS		

FAMILY/OTHER COVERAGE INFORMATION — Complete if claim is for a dependent and/or other coverage is in effect

IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	SPOUSE'S NAME	SPOUSE'S DATE OF BIRTH MONTH DAY YEAR	SPOUSE'S I.D./SOCIAL SECURITY NUMBER ▶	[][]-[][]-[][][][]
NAME OF SPOUSE'S EMPLOYER: STATE ADDRESS		CITY	STATE	ZIP
		SPOUSE'S EMPLOYER TEL. NO. () AREA CODE		IS PATIENT EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO
IS PATIENT COVERED BY ANOTHER GROUP BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF OTHER COMPANY/ORGANIZATION PROVIDING BENEFITS			
POLICY/PLAN NUMBER	ADDRESS OF OTHER ORGANIZATION PROVIDING BENEFITS		STREET	CITY STATE ZIP

EMPLOYEE'S/PATIENT'S SIGNATURE AND RELEASE — Employee must sign all claims
 Dependent patient must sign also (if not a minor)

CERTIFICATION — I certify that the foregoing information is true and correct.			
OR			
EMPLOYEE'S SIGNATURE	DATE	DEPENDENT PATIENT'S SIGNATURE - IF NOT A MINOR	DATE
AUTHORIZATION TO RELEASE INFORMATION — I hereby authorize any Provider, Insurer or other Organization to release any information regarding the history, treatment, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefit payable. This authorization or a copy shall be valid for one year from the date of signature.			SIGNED (PATIENT OR PARENT IF MINOR) DATE

TO BE COMPLETED BY 342 INSURANCE TRUST

CLAIM BRANCH NO.	DATE EE. ELIGIBLE MO DAY YEAR	EE. COV IN FORCE <input type="checkbox"/> YES <input type="checkbox"/> NO	EE TERM DATE MO. DAY YEAR	WORK RELATED ILLNESS/INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO	WORKER'S COMP. <input type="checkbox"/> YES <input type="checkbox"/> NO
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THIS SECTION MUST BE COMPLETED BY PROVIDER . . . PLEASE TYPE OR PRINT

EXAMINATION

Patient's Name		Patient's Birth Date	Diagnosis	
Date of Exam	Refraction <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonometry <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact lenses <input type="checkbox"/> Yes <input type="checkbox"/> No	Cataract Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No
If contact lenses were prescribed, please indicate: <input type="checkbox"/> Cosmetic <input type="checkbox"/> Medically necessary (Reason _____)				
TO OPHTHALMOLOGIST ONLY: Was the patient referred to you for an examination of an unresolved visual problem by an Optometrist who performed a vision examination within the last 60 days? <input type="checkbox"/> Yes <input type="checkbox"/> No				

EXAMINATION CHARGE \$

Name of Examiner Who Performed the Services			Phone (Area Code)	
Address			City-State-Zip Code	
Signature		S.S. No. _____		
Date	Degree/Title	Employer I.D. No. _____		
<small>AUTHORIZATIONS TO ASSIGN BENEFITS WILL NOT BE HONORED UNLESS YOUR TAX IDENTIFICATION OR SOCIAL SECURITY NUMBER IS PROVIDED ABOVE</small>				

*Must be
Furnished Under
Authority Law*

LENSES

Date Ordered	Materials <input type="checkbox"/> PLASTIC <input type="checkbox"/> Pair Supplied: <input type="checkbox"/> GLASS <input type="checkbox"/> 1/2 Pair	Seg. Style/Width <input type="checkbox"/> Executive <input type="checkbox"/> Flattop <input type="checkbox"/> Kryptok <input type="checkbox"/> Panoptic <input type="checkbox"/> Round
Type Lens: <input type="checkbox"/> Single Vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Lenticular <input type="checkbox"/> Contact Lenses _____ <input type="checkbox"/> Oversized Lenses _____ <input type="checkbox"/> Sunglasses _____ <input type="checkbox"/> Tint # _____ <input type="checkbox"/> Gradient _____ <input type="checkbox"/> Photosensitive-i.e., Brown, Gray, etc. _____ <input type="checkbox"/> Other (please explain) _____ Lens Manufacturer _____		Charge (including taxes) \$ _____ _____ _____ _____

LENS CHARGE (including taxes) \$

FRAMES

Date Ordered	Parts <input type="checkbox"/> Complete <input type="checkbox"/> Partial	Composition <input type="checkbox"/> ZYL <input type="checkbox"/> Metal <input type="checkbox"/> ZYL Combination
Frame Manufacturer		Frame Name No. of Frames Dispensed?
		FRAME CHARGE (including taxes) \$
		TOTAL CHARGE (including taxes) \$

Name of Provider Who Performed the Services			Phone (Area Code)	
Address			City-State-Zip Code	
Signature		S.S. No. _____		
Date	Degree/Title	Employer I.D. No. _____		
<small>AUTHORIZATIONS TO ASSIGN BENEFITS WILL NOT BE HONORED UNLESS YOUR TAX IDENTIFICATION OR SOCIAL SECURITY NUMBER IS PROVIDED ABOVE</small>				

*Must be
Furnished Under
Authority of Law*

ASSIGNMENT OF BENEFITS EXCEPT WHERE MY PLAN PROVIDES FOR AUTOMATIC PAYMENT OF BENEFITS TO THE PROVIDER OF SERVICES, I AUTHORIZE PAYMENT OF BENEFITS, OTHERWISE PAYABLE TO ME, FOR SERVICES RENDERED BY THOSE PHYSICIANS OR PROVIDERS DESCRIBED ABOVE AND/OR AS INDICATED ON THE ENCLOSED BILLS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE PROVIDER FOR CHARGES NOT COVERED BY ME BENEFIT PLAN.

SIGNED (EMPLOYEE) DATE