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.

A

EMPLOYEE'S NAME: FIRST	MIDDLE INITIAL	LAST	DATE OF BIRTH (MONTH DAY YEAR)	SEX ☐ MALE ☐ FEMALE

EMPLOYEE'S ADDRESS: STREET AND NO.	CITY	STATE	ZIP

IS THIS A NEW ADDRESS? ☐ YES ☐ NO	IS THIS A TEMPORARY ADDRESS? ☐ YES ☐ NO	*EMPLOYEE'S I.D./SOCIAL SECURITY NO* ***CLAIM CANNOT BE PROCESSED WITHOUT THIS NUMBER*** ►

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ LEGALLY SEPARATED ☐ WIDOWED	IS CLAIM THE RESULT OF AN ACCIDENT OR OCCUPATIONAL ILLNESS? ☐ YES ☐ NO IF 'YES' COMPLETE SECTION BELOW.	ARE YOU (EMPLOYEE) COVERED BY ANOTHER GROUP BENEFIT PLAN? ☐ YES ☐ NO IF 'YES' COMPLETE SECTION D BELOW.

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

B

PATIENT'S NAME: FIRST	MIDDLE INITIAL	LAST	RELATIONSHIP TO EMPLOYEE: SPOUSE CHILD OTHER-SPECIFY	DATE OF BIRTH (MONTH DAY YEAR)	SEX ☐ MALE ☐ FEMALE

COMPLETE THIS INFORMATION IF PATIENT IS AN UNMARRIED DEPENDENT CHILD AGE 19 AND OLDER ►	DEPENDENT CHILD IS ☐ EMPLOYED FULL-TIME ☐ 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

C

IS CLAIM DUE TO AN ACCIDENT? ☐ YES ☐ 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

D

IS SPOUSE EMPLOYED? ☐ YES ☐ 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? ☐ YES ☐ NO

IS PATIENT COVERED BY ANOTHER GROUP BENEFIT PLAN? ☐ YES ► ☐ 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)

E

CERTIFICATION — I certify that the foregoing information is true and correct

EMPLOYEE'S SIGNATURE _____ DATE _____

OR

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 ☐ YES ☐ NO	EE TERM DATE (MO DAY YEAR)	WORK RELATED ILLNESS/INJURY ☐ YES ☐ NO	WORKER'S COMP ☐ YES ☐ NO

1/1/92

EXAMINATION

THIS SECTION MUST BE COMPLETED BY PROVIDER . . . PLEASE TYPE OR PRINT

Patient's Name	Patient's Birth Date	Diagnosis

Date of Exam	Refraction ☐ Yes ☐ No	Tonometry ☐ Yes ☐ No	Contact lenses ☐ Yes ☐ No	Cataract Surgery ☐ Yes ☐ No
	If contact lenses were prescribed, please indicate: ☐ Cosmetic ☐ 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? ☐ Yes ☐ No

EXAMINATION CHARGE $

Name of Examiner Who Performed the Services	Phone (Area Code)

Address	City-State-Zip Code

Signature	S.S. No. _____ *Must be Furnished Under Authority Law*
Date / Degree/Title	Employer I.D. No. _____

AUTHORIZATIONS TO ASSIGN BENEFITS WILL NOT BE HONORED UNLESS YOUR TAX IDENTIFICATION OR SOCIAL SECURITY NUMBER IS PROVIDED ABOVE

LENSES

Date Ordered	Materials Supplied: ☐ PLASTIC ☐ GLASS	☐ Pair ☐ ½ Pair	Seg. Style/Width ☐ Executive ☐ Panoptic ☐ Flattop ☐ Round ☐ Kryptok ☐ _____

Type Lens:

☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Lenticular ☐ Contact Lenses _____

☐ Oversized Lenses _____

☐ Sunglasses _____

☐ Tint # _____ ☐ Gradient _____

☐ Photosensitive-i.e., Brown, Gray, etc _____

☐ Other (please explain) _____

Lens Manufacturer _____

Charge (including taxes)

$ _____

LENS CHARGE (including taxes) $

Date Ordered	Parts ☐ Complete ☐ Partial	Composition ☐ ZYL ☐ Metal ☐ ZYL Combination	

Frame Manufacturer	Frame Name No. of Frames Dispensed?
	FRAME CHARGE (including taxes) $
	TOTAL CHARGE (including taxes) $

FRAMES

Name of Provider Who Performed the Services	Phone (Area Code)

Address	City-State-Zip Code

Signature	S.S. No. _____ *Must be Furnished Under Authority of Law*
Date / Degree/Title	Employer I.D. No. _____

AUTHORIZATIONS TO ASSIGN BENEFITS WILL NOT BE HONORED UNLESS YOUR TAX IDENTIFICATION OR SOCIAL SECURITY NUMBER IS PROVIDED ABOVE.

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