

PART A - TO BE COMPLETED BY EMPLOYEE

STATEMENT OF VISION CARE (Examinations and Materials)

1. PATIENT'S NAME (First name, middle initial, last name) _____ 2. PATIENT'S DATE OF BIRTH _____

3. EMPLOYEE'S NAME (First name, middle initial, last name) _____

4. PATIENT'S ADDRESS (If different from employee) _____ 5. PATIENT'S SEX _____

6. EMPLOYEE ADDRESS IS THIS A NEW ADDRESS? YES NO

CITY _____ STATE _____ ZIP _____

7. PATIENT'S RELATIONSHIP TO INSURED
 SELF SPOUSE CHILD OTHER

8. EMPLOYEE'S SOC. SEC. NO. _____

9. EMPLOYEE'S EMPLOYER _____

10. EMPLOYEE'S DATE OF BIRTH _____ 11. ACTIVE RETIRED
 EFF. DATE OF RETIREMENT _____

12. ANY OTHER VISION CARE BENEFITS FOR EMPLOYEE, SPOUSE OR PATIENT? (CHECK ONE OF FOLLOWING) YES NO
 WHO? SELF SPOUSE DEPENDENT: IF DEPENDENT OR SPOUSE, FULL NAME _____ DATE OF BIRTH _____
 COVERAGE PROVIDED THROUGH BLUE CROSS/BLUE SHIELD MEDICARE OR CHAMPUS HEALTH MAINTENANCE ORGANIZATION (HMO)
 EMPLOYER SPONSORED PLAN COMMERCIAL INSURANCE COMPANY MEDICAID OTHER
 GIVE NAME AND ADDRESS OF OTHER COVERAGE ABOVE _____

13. ARE OTHER FAMILY MEMBERS EMPLOYED? YES NO
 EMPLOYEE NAME _____ SOC. SEC. NO. _____
 IF YES _____

14. WAS CONDITION RELATED TO
 A. PATIENT'S EMPLOYMENT?
 YES NO
 B. AN ACCIDENT?
 YES NO

15. IF AN ACCIDENT
 date _____ 19____ and time _____ A.M. P.M.
 description (how & where) _____

17. To all physicians and other health professionals and all hospitals and other health care institutions:
 You are authorized to provide Island Group Administration, Inc. and any independent claim administrators and consulting health professionals and utilization review organizations with whom Island Group Administration, Inc. has contracted, information concerning health care, advice, treatment, or supplies provided the Patient (including that relating to mental illness). This information will be used for the purpose of evaluating and administering claims for benefits Island Group Administration, Inc. may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract.
 This authorization is valid for the term of coverage of the policy or contract under which a claim has been submitted.
 I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Date: _____ Patient's or Authorized Person's Signature _____

PART B - TO BE COMPLETED BY DOCTOR

18. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR AND/OR DISPENSER OF THE VISION CARE BENEFITS OTHERWISE PAYABLE TO ME.
 SIGNED (EMPLOYEE) _____ (DATE) _____

1. DOCTOR'S NAME (Last, First, Middle) _____ 2. ENTER THE TAXPAYER IDENTIFYING NUMBER TO BE USED FOR 1099 REPORTING PURPOSES.
 YOU ARE REQUIRED UNDER AUTHORITY OF LAW TO FURNISH YOUR TAXPAYER IDENTIFYING NUMBER.

		PROFESSIONAL SERVICES	AMOUNT
3. DOCTOR'S ADDRESS (No., Street, City, State, Zip) _____		EXAMINATION CHARGE	
4. PHONENO. (Area Code) _____	5. TITLE _____ <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> O.D.	SALES TAX (If Any)	
6. EXAMINATION DATE(S) _____	7. HAS CATARACT SURGERY BEEN PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No	TOTAL	
8. CAN VISUAL ACUITY BE RESTORED TO 20/70 IN BETTER EYE WITH CONVENTIONAL EYEGLASSES? <input type="checkbox"/> Yes <input type="checkbox"/> No	9. DOES PATIENT REQUIRE A PRESCRIPTION CHANGE AT THIS TIME? <input type="checkbox"/> Yes <input type="checkbox"/> No	AMOUNT PAID BY PATIENT	
10. DIAGNOSTIC CODE(S) _____			
11. INDICATE DIAGNOSIS OR NATURE OF DISEASE OR INJURY OR VISION DISORDER, INDICATE PROCEDURE CODE #'s _____			
		12. VISUAL ACUITY CORRECTED TO: _____	

13. DOCTOR'S PRESCRIPTION

Sphere	Cylinder	Axis	Prism	Base
R.E. _____	• _____	• _____		
L.E. _____	• _____	• _____		
READING ADD _____	R.E. _____	+ • _____	L.E. _____	+ • _____

14. I hereby certify that I have performed the services as indicated hereon.
 DOCTOR'S SIGNATURE _____ DATE _____

PART C - TO BE COMPLETED BY DISPENSER

IN LIEU OF DISPENSER COMPLETING THIS SECTION A LABORATORY BILL CAN BE ATTACHED. DISPENSER MUST SIGN THIS FORM, ENTER AMT. PD. BY PATIENT

1. DISPENSER'S NAME (Last, First, Middle) _____ 2. ENTER THE TAXPAYER IDENTIFYING NUMBER TO BE USED FOR 1099 REPORTING PURPOSES.
 YOU ARE REQUIRED UNDER AUTHORITY OF LAW TO FURNISH YOUR TAXPAYER IDENTIFYING NUMBER.

		PROFESSIONAL SERVICES	AMOUNT
3. DISPENSER'S ADDRESS (No., Street, City, State, Zip) _____		LENS CHARGE	
4. PHONE NO. (& Area Code) _____		FRAME CHARGE	
5. DISPENSER'S TITLE _____ <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Optician <input type="checkbox"/> Optometrist	6. MATERIALS SUPPLIED Tint # _____ <input type="checkbox"/> Oversized <input type="checkbox"/> Glass <input type="checkbox"/> Plastic <input type="checkbox"/> Pair <input type="checkbox"/> 1/2 Pair <input type="checkbox"/> Other _____	OPT. LENS	
7. DATE _____ ORDER _____ DELIVERY _____		FRM	
8. TYPE OF LENSES DISPENSED <input type="checkbox"/> None <input type="checkbox"/> Single <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Lenticular <input type="checkbox"/> Contacts <input type="checkbox"/> Sunglasses <input type="checkbox"/> Other (Specify) _____		DISP. FEE LENS	
9. CONTACT LENSES (If Contact Lenses, Please Complete) <input type="checkbox"/> Therapeutic <input type="checkbox"/> Non-Therapeutic <input type="checkbox"/> Hard Lenses <input type="checkbox"/> Soft Lenses		FRM	
10. FRAME MODEL OR CAT. NO. & SIZE _____		SALES TAX (If Any)	
11. FRAME MFT. NAME _____		TOTAL	
12. I hereby certify that I have performed the services as indicated hereon.		AMOUNT PAID BY PATIENT	

DISPENSER'S SIGNATURE _____ DATE _____

VISION CARE BENEFITS REQUEST FORM

ISLAND GROUP ADMINISTRATION, INC.

3-5 Toilsome Lane
East Hampton, NY 11937-6046
631-324-2306

HOW TO REQUEST BENEFITS

EMPLOYEE

COMPLETE THE "PATIENT INFORMATION" (PART A — ITEMS 1 THROUGH 18) ON THE REVERSE SIDE OF THIS FORM.

If you wish your benefits paid directly to your Doctor or Optometrist, sign item 18. If you wish benefits paid directly to the provider of materials, sign item 18. A separate form should be submitted for each family member.

Please be sure you have provided the employee's Social Security Number.

SEND THE COMPLETED "BENEFIT REQUEST FORM" DIRECTLY TO ISLAND GROUP ADMINISTRATION, INC.

**DOCTOR
OR
OPTOMETRIST**

PLEASE COMPLETE PART B OF THE REVERSE SIDE OF THIS FORM (EXAMINING DOCTOR OR OPTOMETRIST INFORMATION) AND SIGN YOUR NAME. PLEASE RETURN THE COMPLETED FORM TO YOUR PATIENT.

**DISPENSER
OF
MATERIAL**

PLEASE COMPLETE PART C OF THE REVERSE SIDE OF THIS FORM (SUPPLIER INFORMATION) AND RETURN THE COMPLETED FORM TO THE PATIENT.

Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.