

PART A - TO BE COMPLETED BY EMPLOYEE

STATEMENT OF VISION CARE (Examinations and Materials)				3. EMPLOYEE'S NAME (First name, middle initial, last name)																					
1. PATIENT'S NAME (First name, middle initial, last name)		2. PATIENT'S DATE OF BIRTH		6. EMPLOYEE ADDRESS IS THIS A NEW ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO																					
4. PATIENT'S ADDRESS (If different from employee)		5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		CITY STATE ZIP																					
CITY STATE ZIP PHONE NO.	7. PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER			8. EMPLOYEE'S SOC. SEC. NO. □□□-□□-□□□□																					
FULL TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHERE?		9. EMPLOYEE'S EMPLOYER		10. EMPLOYEE'S DATE OF BIRTH																					
				11. <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED EFF. DATE OF RETIREMENT																					
12. ANY OTHER VISION CARE BENEFITS FOR EMPLOYEE, SPOUSE OR PATIENT? (CHECK ONE OF FOLLOWING) <input type="checkbox"/> YES <input type="checkbox"/> NO WHO? <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT. IF DEPENDENT OR SPOUSE, FULL NAME _____ DATE OF BIRTH _____ COVERAGE PROVIDED THROUGH <input type="checkbox"/> BLUE CROSS/BLUE SHIELD <input type="checkbox"/> MEDICARE OR CHAMPUS <input type="checkbox"/> HEALTH MAINTENANCE ORGANIZATION (HMO) <input type="checkbox"/> EMPLOYER SPONSORED PLAN <input type="checkbox"/> COMMERCIAL INSURANCE COMPANY <input type="checkbox"/> MEDICAID <input type="checkbox"/> OTHER GIVE NAME AND ADDRESS OF OTHER COVERAGE ABOVE _____																									
13. ARE OTHER FAMILY MEMBERS EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO EMPLOYEE NAME SOC. SEC. NO. IF YES		14. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		15. IF AN ACCIDENT date _____ 19____ and time _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. description (how & where) _____																					
16. NAME AND ADDRESS OF EMPLOYER IN ITEM 13.		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 _____																							
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.																						
3. DOCTOR'S ADDRESS (No., Street, City, State, Zip)			PROFESSIONAL SERVICES		AMOUNT																				
4. PHONENO. (Area Code)	5. TITLE <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> O.D.	6. EXAMINATION DATE(S)	7. HAS CATARACT SURGERY BEEN PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No		EXAMINATION CHARGE																				
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		SALES TAX (If Any)																					
10. DIAGNOSTIC CODE(S) _____			TOTAL																						
11. INDICATE DIAGNOSIS OR NATURE OF DISEASE OR INJURY OR VISION DISORDER, INDICATE PROCEDURE CODE #'s			12. VISUAL ACUITY CORRECTED TO:		AMOUNT PAID BY PATIENT																				
13. DOCTOR'S PRESCRIPTION			14. I hereby certify that I have performed the services as indicated hereon.																						
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th>Sphere</th> <th>Cylinder</th> <th>Axis</th> <th>Prism</th> <th>Base</th> </tr> <tr> <td>R.E.</td> <td>•</td> <td></td> <td></td> <td></td> </tr> <tr> <td>L.E.</td> <td>•</td> <td></td> <td></td> <td></td> </tr> <tr> <td>READING ADD</td> <td>R.E.</td> <td>+</td> <td>L.E.</td> <td>+</td> </tr> </table>			Sphere	Cylinder	Axis	Prism	Base	R.E.	•				L.E.	•				READING ADD	R.E.	+	L.E.	+	DOCTOR'S SIGNATURE _____ DATE _____		
Sphere	Cylinder	Axis	Prism	Base																					
R.E.	•																								
L.E.	•																								
READING ADD	R.E.	+	L.E.	+																					
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.																						
3. DISPENSER'S ADDRESS (No., Street, City, State, Zip)			4. PHONE NO. (& Area Code)		PROFESSIONAL SERVICES																				
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"/> Other _____ <input type="checkbox"/> Pair <input type="checkbox"/> 1/2 Pair		AMOUNT																				
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) _____			7. DATE ORDER DELIVERY		LENS CHARGE																				
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			10. FRAME MODEL OR CAT. NO. & SIZE		FRAME CHARGE																				
12. I hereby certify that I have performed the services as indicated hereon.			11. FRAME MFT. NAME		OPT. LENS																				
DISPENSER'S SIGNATURE _____			DATE _____		FRM																				
					DISP. FEE LENS																				
					FRM																				
					SALES TAX (If Any)																				
					TOTAL																				
					AMOUNT PAID BY PATIENT																				

PART B - TO BE COMPLETED BY DISPENSER

**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.