Vision Claim Form

Return this form to:

Group Administrators, Ltd.
Attention: Claim Department
953 American Lane, Suite 100
Schaumburg, IL 60173

You may also fax this form and bills and/or receipts to 1-847-519-1979.

Section 1 – Member's Statement *Please Print (Attach All Bills).*

Member's Social Security No.	*Member's Full Name*	Member's Birth Date	*Mo.*	*Day*	*Yr.*	*Sex*

If address has changed since last claim place "X" in this box ☐	*Member's Street Address*	*Member's City & State*	*Zip Code*

Member's Home Phone Number

If this claim is for a dependent, also fill out this part	*Relationship of Dependent*	*Dependent's First Name & Initial*	*Dependent Birth Date* Mo.	Day	Yr.	Age

☐ Yes ☐ No ☐ Yes ☐ No

ASSIGNMENT OF BENEFITS:
Do you want us to pay your doctor directly? ☐ Yes ☐ No

The statements on this form are true and correct to the best of my knowledge.

NOTICE: It is illegal to file a false or fraudulent claim or to knowingly help someone else file one. You may be fined or sent to prison for doing so. You may also be required to pay civil damages.

Employee's Signature	*Date*