

**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*

Revised 6/12/2019