PREFERRED GROUP
CUSTOM BENEFITS SOLUTIONS

STATEMENT OF CLAIM
BRONXVILLE PUBLIC SCHOOL EMPLOYEES' B.T. GROUP VISION CARE BENEFITS

TO BE COMPLETED BY THE EMPLOYEE

1. PATIENT NAME	2. RELATIONSHIP TO EMPLOYEE SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	3. SEX M ☐ F ☐	4. PATIENT BIRTHDATE MO. DAY YEAR	5. IF FULL TIME STUDENT SCHOOL CITY
6. EMPLOYEE NAME FIRST MIDDLE LAST	7. EMPLOYEE SOC. SEC. NO.		8. NAME OF GROUP **BRONXVILLE PUBLIC SCHOOL EMPLOYEES' B.T.**	
9. EMPLOYEE MAILING ADDRESS			EMPLOYER (COMPANY) NAME AND ADDRESS	
CITY, STATE, ZIP				
10. SPOUSES NAME	4. SPOUSES BIRTHDATE MO. DAY YEAR		SPOUSES I. D. SOCIAL SECURITY NUMBER	
11. ARE OTHER FAMILY MEMBERS EMPLOYED? IF "YES", INDICATE NAME ☐ YES ☐ NO SOC. SEC. NO.			12. NAME AND ADDRESS OF EMPLOYER IN ITEM 11	
13. IS PATIENT COVERED BY ANOTHER PLAN? ☐ YES ☐ NO	PLAN NAME	UNION LOCAL	GROUP NO.	NAME AND ADDRESS OF CARRIER

I authorize any individual or organization to release any information to Preferred Group Plans, Inc. for any services or benefits received or payable to me or on my behalf.

REQUIRED STATEMENT: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information, or conceals for the purpose of misleading, information concerning any fact materials thereto, commits a fraudulent insurance act, which is a crime."

Signature of Eligible Insured _____ **Date** _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I AUTHORIZE PAYMENT OF VISION BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.

Signature of Insured _____ **Date** _____

TO BE COMPLETED BY PROVIDER OF MATERIALS OR VISION CARE SERVICES

OPTOMETRIST/OPTHALMOLOGIST/OPTICIAN			**WHAT IS PATIENTS PRESENT DEGREE OF VISUAL ACTIVITY?**
MAILING ADDRESS			**CORRECTED** _____ **UNCORRECTED** _____
CITY, STATE, ZIP			**IF TINTED GLASSES WERE FURNISHED, WERE THEY SPECIFICALLY PRESCRIBED FOR MEDICAL REASONS? YES** _____ **NO** _____
SOC. SEC. OR T.I.N. #	LICENSE NO.	PHONE ( )	**PLEASE INDICATE REASON**

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

DESCRIPTION OF SERVICES	DATE OF SERVICE	FEE	DESCRIPTION OF SERVICES	DATE OF SERVICE	FEE
EXAMINATION			CONTACT LENSES		
SINGLE VISION LENSES			OTHER CHARGES		
BIFOCAL LENSES					
TRIFOCAL LENSES					
FRAME ONLY			TOTAL CHARGES		

I HEREBY CERTIFY THAT THE SERVICES/MATERIALS AS INDICATED HAVE BEEN PROVIDED.

_____ _____
Signed Date

MAIL CLAIM FORM TO:
PREFERRED GROUP PLANS
P.O. BOX 15136
ALBANY, NY 12212-5136
Attn: Claims Dept.