NVA
Attn: ShelterPoint
P.O. Box 2187
Clifton, NJ 07015

1-877-241-7124

VISION CARE
Statement of Claim

PART 1 EMPLOYER/PLAN ADMINISTRATOR

INSURED	EMPLOYEE ID NUMBER *(If applicable)*	GROUP NAME	POLICY NO.

DATE BENEFITS BECAME EFFECTIVE Mo Day Year EMP. / Mo Day Year DEP.	DATE TERMINATED Mo Day Year	SIGNATURE OF AUTHORIZED PERSON	DATE

PART 2 TO BE COMPLETED BY INSURED

1. PATIENT NAME	2.RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER	3. SEX M F	4. PATIENT BIRTHDATE MO DAY YEAR	5. IF FULL TIME STUDENT SCHOOL CITY

6. INSURED NAME FIRST NAME MIDDLE LAST	7. EMPLOYEE SOCIAL SECURITY NO.	9. EMPLOYER
8. MAILING ADDRESS	10 ARE OTHER MEMBERS EMPLOYED ? ☐ YES ☐ NO If Yes, Indicate NAME SOC. SEC. NO.	
CITY, STATE, ZIP	11. NAME AND ADDRESS OF EMPLOYER IN ITEM 10	
12. 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 ShelterPoint Life Insurance Company or its affiliates for any services or benefits received or payable to me or on my behalf.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and stated value of the claim for each such violation.

Signature of Eligible Insured ____________________ Date __________

I authorize payment of vision benefits to the undersigned physician or supplier for service described below.

Signature of Insured ____________________ Date __________

PART 3 TO BE COMPLETED BY OPTOMETRIST OR OPHTHALMOLOGIST

1. OPTOMETRIST/OPTHALMOLOGIST			7. IS TREATMENT RESULT OF OC-CUPATIONAL IL-LNESS OR INJURY ? No Yes IF YES, ENTER BRIEF DESCRIPTION AND DATES
2. MAILING ADDRESS			8. IS TREATMENT RESULT OF AUTO ACCIDENT ?
3. CITY, STATE, ZIP			9. OTHER ACCIDENT ?
4. SOC.SEC. OR T.I.N.	5. LICENSE NO.	6. PHONE NO.	10.ARE ANY SERVICES COVERED BY ANOTHER PLAN ?

11. DESCRIPTION OF SERVICES	DATE OF SERVICE	FEE
A. EXAMINATION		
B. SINGLE VISION WITH FRAME		
C. BIFOCAL WITH FRAME		
D. FRAME ONLY		

11. DESCRIPTION OF SERVICES	DATE OF SERVICE	FEE
E.LENSES ONLY 1) SINGLE VISION		
2) BIFOCAL		
F.CONTACT LENSES		
G.OTHER		
H.TOTAL CHARGES		

12. PLEASE COMPLETE THE FOLLOWING;

A. WERE LENSES PRESCRIBED AS A RESULT OF EYE SURGERY ? YES______ NO _______

IF "YES" PLEASE SPECIFY PROCEDURE____________________

____

B. WHAT IS PATIENT'S PRESENT DEGREE OF VISUAL ACUITY ?

CORRECTED __________ **UNCORRECTED** __________

C. IF TINTED GLASSES WERE FURNISHED, WERE THEY SPECIFICALLY PRESCRIBED FOR MEDICAL REASONS?

YES __________ **NO** __________

D. PLEASE SIGN BELOW

____

SIGNATURE **DATE**

GVC1(a) XGMM (Rev. 5-15)