J.J. Stanis & Company, Inc.
377 Oak Street – Suite 406
Garden City, NY 11530

**Statement of Claim**
FOR
GROUP VISION CARE BENEFITS

TO BE COMPLETED BY THE MEMBER:

| PATIENT NAME: | RELATIONSHIP TO EMPLOYEE: SELF SPOUSE CHILD OTHER | Sex M F | Patient Date of Birth Month/Date/Year / / | If Full Time Student: School/City |
|---|---|---|---|---|
| Employee Name: First Middle Last | Employee SSN / / | Name of Group Vision Program | | |
| Employee Mailing Address | | Employer (Company) Name and Address | | |
| City, State, Zip | | | | |
| Spouse's Name | Spouse's Date of Birth Month/Date/Year / / | Spouse's ID Social Security Number / / | | |
| Are other family members employed? _____ Yes ___ No Name | Social Security Number | Name and address of employer | | |
| If Yes, indicate | | | | |
| Is Patient Covered by another Plan? _____ Yes _____ No | Plan Name | Union/Local | Group Number | Name and Address of Carrier |

I authorize any individual or organization to release any information to J. J. Stanis and Company Inc. and/or CBCA for any services or benefits received or payable to me or on my behalf.
REQUESTED 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 nay fact material 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/Ophthalmogist/Optician: | I HEREBY CERTIFY THAT THE SERVICES/MATERIALS AS INDICATED HAVE BEEN PROVIDED |
|---|---|
| Mailing Address: | SIGNATURE: _____ |
| City/State/Zip: | DATE: _____ |
| SSN or Tin: License No Phone No ( ) - | |
| Diagnosis or Nature of Illness of Injury: | |

| Description of Services | Date | Fee | Description of Services | Date | Fee |
|---|---|---|---|---|---|
| Examination | | | Contact Lenses | | |
| Single Vision Lenses | | | Other | | |
| Bifocal Lenses | | | | | |
| Trifocal Lenses | | | | | |
| Frame Only | | | TOTAL CHARGES | | |

To access additional claim forms, please visit our website: www.jjstanisco.com