SOUTHERN TIER BUILDING TRADES BENEFIT PLAN

202 WEST FOURTH ST. • JAMESTOWN, NY 14701 • PHONE (716) 664-4392

TO BE COMPLETED AND SIGNED BY THE INSURED

VISION CARE PROVIDER STATEMENT

INSURED'S NAME	MARITAL STATUS MARRIED ☐ SINGLE ☐	DATE OF BIRTH
HOME ADDRESS		TELEPHONE NUMBER
INSURED'S SOCIAL SECURITY NUMBER	PATIENT'S NAME	
DESCRIPTION OF ACCIDENT OR SICKNESS		

IS THIS INJURY OR SICKNESS DUE TO: AUTOMOBILE ACCIDENT YES ☐ NO ☐ EMPLOYMENT YES ☐ NO ☐

HAVE YOU ENTERED A CLAIM UNDER YOUR HOME OWNER'S POLICY YES ☐ NO ☐

MUST BE COMPLETED ON THE SPOUSE

NAME (FIRST)	DATE OF BIRTH
SOCIAL SECURITY NO.	
EMPLOYER'S NAME AND ADDRESS	
NAME OF YOUR INSURANCE COMPANY	

TO BE COMPLETED IF CLAIM ON DEPENDENT CHILD

NAME	
DATE OF BIRTH	SOCIAL SECURITY NUMBER
FULL TIME STUDENT YES ☐ NO ☐	EMPLOYED YES ☐ NO ☐
NAME OF SCHOOL ATTENDING	
NAME & ADDRESS OF EMPLOYER	

PAYMENT IS TO BE PAID DIRECTLY TO THE (SELECT ONE) INSURED ☐ PROVIDER ☐

I HEREBY AUTHORIZE ANY PHYSICIAN, DENTIST, HOSPITAL, PHARMACY, INSURANCE COMPANY, EMPLOYER OR ORGANIZATION TO RELEASE ANY INFORMATION REGARDING THE MEDICAL HISTORY, TREATMENT, DISABILITY, OR BENEFITS PAYABLE FOR THIS CLAIM, TO SOUTHERN TIER BUILDING TRADES BENEFIT PLAN. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

SIGNATURE OF INSURED ____________________ DATE ____________

VISION CARE PROVIDER STATEMENT

DATE OF SERVICE	DESCRIPTION OF SERVICE		FEE	ADMINISTRATIVE USE ONLY
	EXAMINATION			
	EYE GLASS (FRAMES AND/OR LENSES)			
	CONTACT LENSES			
WE DO NOT PAY FOR PRESCRIPTION SUN GLASSES		TOTAL FEE ►		

I HEREBY CERTIFY THAT THE SERVICES ABOVE HAVE BEEN COMPLETED.

SIGNATURE DATE

PROVIDER'S NAME (PRINT)	SOCIAL SECURITY NO. OR I.D. NO.	LICENSE NO.	PHONE NO.
STREET ADDRESS	CITY OR TOWN	STATE	ZIP CODE

OFFICE USE ONLY

ELIGIBLE

YES ☐ NO ☐

DATE REC'D ____________

PROCESSED BY ____________

REV. 07-89