Allied Benefit Systems, Inc.
PO Box 909786-60690
Chicago, IL 60690
Phone: (800) 288-2078
Fax: (312) 906-8359

Vision Claim Form

Please complete the applicable items in Part 1 and give the form your Provider and Dispenser to complete Parts 2 and 3. Please return the completed form to Allied Benefit Systems Inc. Please submit an itemized bill along with this claim form.

Part 1: To be completed by Employee/Patient

Employer Information

Employer Name	Group Number
Village of Rosemont	97050

Employee Information

Employee Name	Social Security Number	Birthdate	
Employee Address	**City**	**State**	**Zip**

Do you or any of your dependents have other group vision coverage?

[ ] Yes (please provide information below) [ ] No

Name of Individual with other coverage	Other Insurance Carrier or TPA		
Address of Carrier or TPA	**City**	**State**	**Zip**

Patient Information

Patient Name	Gender	Birthdate

Relationship to Employee

[ ] Self [ ] Spouse [ ] Child [ ] Other:

Claim Information

Was this claim due to an accident?	If yes, what was the date of the accident?
[ ] Yes [ ] No	
Where did the accident occur?	**Is this claim the result of a work related illness or injury?**
	[ ] Yes [ ] No

Provider Information

Provider Name	Patient Name	Date of Service	Total Charge

Employee Authorization

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of vision treatment.

Employee Signature ____________________ Date ____________________

ASSIGNMENT OF BENEFITS: I hereby authorize payment to the provider of vision services which are otherwise payable to me for services rendered. Payment will be made in accordance with the provisions of the benefit plan.

Employee Signature ____________________ Date ____________________