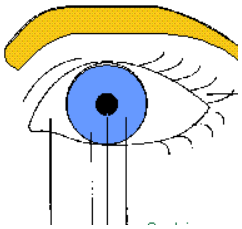
G.U.T. GROUP MEDICAL PLAN

P.O Box 452, Marine Villa, St. George
PHONE: 440-5988/3248 FAX: 444-5988
Email: medplan95@yahoo.com /medical.p2013@gmail.com



VISION CLAIM FORM

1. Member/Employee's Name_____
2. Home Address _____
3. Name of Employer _____
4. Claim incurred by (Patient)_____
5. Relationship of patient to Member/employee: _____Date of birth (of child)_____
6. Name of attending physician _____
7. Is spouse employed? _____ if yes name of employer _____
8. Are you or any of your dependents covered by any other Health Insurance Plan providing benefits for this injury or sickness? _____

   If yes give (a) Name of Insurance Company _____

   (b) if Group Plan, Name of Group or Company Insured under_____
9. Check if statements\bills for ALL expenses are attached in support of your claim **___YES ___No**

I hereby certify that the foregoing answers are true and correct to the best of my knowledge and herby authorize all doctors or other persons who treated me and all hospitals or other Institutes to furnish full information (including full copies of their records) regarding this claim to the G.U.T GROUP MEDICAL PLAN.

DATE_____20___ _____ _____
SIGNATURE OF MEMBER/EMPLOYEE **SIGNATURE OF SPOUSE (IF PATIENT)**

SCHOOL OR INSTITUTION_____

PREVIOUS SCHOOL OR INSTITUTION_____

Contact Number(s)_____ **Email Address:**_____

TO BE COMPLETED BY OPTOMETRIST\OPHTHALMOLOGIST\OPTICIAN

Diagnosis _____

Did prescription change for [ ] Right Eye [ ] Left Eye Date Dispensed:_____

Cost of **Visual Examination** $_____

TO BE COMPLETED FOR CONTACT LENSES

1. Were contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus or aphakia? [ ] Yes [ ] No

2. Can visual acuity be improved by up to at least 20/70 level by contact lenses? [ ] Yes [ ] No

3. Could visual acuity be improved up to at least the 20/70 level by spectacle lenses? [ ] Yes [ ] No

……. **……**

DATE **SIGNATURE OF OPTOMETRIST\OPHTHALMOLOGIST\OPTICIAN**

TO BE COMPLETED BY SUPPLIER

Optical supplies furnished by:

Name _____ Address_____

PLEASE INDICATE THE COST OF EACH PROCEDURE PERFORMED:

a) Laboratory cost of lenses _____
Please specify type of lenses
[ ] Single [ ] Bifocal
[ ] Multifocal [ ] Lenticular

b) Cost of frames _____

c) Tinting _____
Specify Tone Light [ ] 1 [ ] 2 [ ] 3

d) Photogrey\Photosun _____

e) Oversize _____

f) Hardex/Safety Materials _____

Are these:
Prescription sun glasses [ ] Yes [ ] No
Replacement of lost or damaged glasses? [ ] Yes [ ] No

OTHER, PLEASE SPECIFY (DRUGS ETC)

_____

_____

_____

……. **……**

DATE **SIGNATURE OF OPTOMETRIST\OPHTHALMOLOGIST\OPTICIAN**

I hereby authorize payment directly to the above-named **OPTOMETRIST\OPHTHALMOLOGIST\OPTICIAN** of the Group Insurance benefits otherwise payable to me, but not to exceed the charges shown. I understand that I am financially responsible for any charges not covered by this authorization.

_____ _____

Signed (Insured person) **Date**