EMPLOYEES SECURITY FUND OF THE ELECTRICAL PRODUCTS INDUSTRIES

158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365-3017 ● (718) 591-1100 ● FAX (718) 591-4200

OPTICAL BENEFIT REQUEST FORM

Participant Information (Please Print)

1. Name *(First Name, Middle Name, Last Name)*	**2. Soc. Sec. No.**	**3. Company Name**
4. Address *(Is this a new address? Yes No)*		**5. Phone #** ( ) -
6. Is spouse of participant covered by another medical benefits plan? Yes ☐ No ☐ If yes, name of other insurance carrier		

Patient Information (Please Print)

7. Name *(First Name, Middle Name, Last Name)*	**8. Soc. Sec. No.**	**9. Birth Date**	**10. Full-time Student?** Yes ☐ No ☐
11. Address *(If different from member)*		**12. Phone #** ( ) -	

13. Patient's Relationship to: Self ☐ Spouse ☐ Child ☐	**14. Patient's Sex:** Male ☐ Female ☐	**15. Was condition related to:** Patient's Employment ? Yes☐ No☐ An auto accident? Yes☐ No☐

Sign below in order for this claim to be processed

16. I authorize the release of any information relating to this claim for the purpose of evaluating and administering benefits.

*Patient's (or Parent's Signature)*_____ *Date:*_____

*Participant's Signature*_____ *Date:* _____

Sign below in order for payment to be made directly to physician or Supplier of Service

17. I authorized payment of medical benefits to physician or supplier of medical services listed below.

*Patient's (or Parent's Signature)*_____ *Date:*_____

Participant's Signature _____ *Date:*_____

Information From Provider or Supplier of Service (Please attach bills)

Name of referring optical provider

Name and address of facility where services were rendered

Procedures, Services, Supplies Furnished

Date of Service	Place of Service	C.P.T. Code	Description of Service	Charges	FOR OFFICE USE ONLY

Name of Provider or Supplier	Taxpayer Identifying Number	Total Charge	Amount Paid

Address

_____

Provider or Supplier's Signature

_____ _____

Date *Phone#*

FOR OFFICE USE ONLY

ESF #	Claims Clerk
Check date	Checked by

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INSTRUCTIONS

1. ALL CLAIMS MUST BE SUBMITTED DIRECTLY TO:

EMPLOYEES SECURITY FUND
158-11 Harry Van Arsdale Jr. Avenue
Flushing, NY 11365-3017

2. We will be unable to process your claim until all information and papers have been received.

Submit **original itemized bills *only*** from each provider and facility. Copies are not acceptable**. (An itemized bill is one that shows the patient's name, relationship, date of service, the type of service rendered, and the provider's or supplier's taxpayer identifying number).**

IMPORTANT

All Optical Benefit claims must be filed no later than twelve (12) months after date of service.

The recipient of benefits under this Fund, by applying for, and in fact accepting such benefits, agrees to reimburse the fund for all such benefits received, from the proceeds of any claim, settlement, judgment or other recovery from a third party, or his insurer, whose conduct caused the injuries which were the basis for the claim for benefits under this Fund.