# EMPLOYEES SECURITY FUND OF THE ELECTRICAL PRODUCTS INDUSTRIES

158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365-3017 • (718) 591-1100 • FAX (718) 591-2189

## 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<br>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

**FOR OFFICE USE ONLY**

| ESF # | Claims Clerk |
|---|---|
| | |
| Check date | Checked by |
| | |

_____
*Provider or Supplier's Signature*

_____ _____
*Date* *Phone#*

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# OPTICAL BENEFIT REQUEST FORM

## 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.