

EMPLOYEES SECURITY FUND OF THE ELECTRICAL PRODUCTS INDUSTRIES

158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365-3017 • (718)591-1100 • (718) 591-2198

OPTICAL BENEFIT REQUEST FORM

Participant Information (Please Print)

1. NAME (First Name, Last Name)	2. Soc. Sec. No.	3. Company Name
4. Address (Is this a new address? Yes <input type="checkbox"/> No <input type="checkbox"/>		5. Phone # () -
6. Is spouse of participant covered by another plan? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, name of other insurance carrier

Patient Information (Please Print)

7. Name (First Name, Last Name)	8. Soc. Sec. No.	9. Birth Date	10. Full-time Student? Yes <input type="checkbox"/> No <input type="checkbox"/>
11. Address (if different from member)		12. Phone # () -	
13. Patient's Relationship to: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>			

Sign below for this claim to be processed

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

Patients (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

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

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

Participant's Signature _____ *Date:* _____

Information From Physician Or Supplier of Service (Please attach bills)

Name of referring physician
Name and address where services 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 Physician or Supplier			Taxpayer Identifying No.		Total Charge
Address				FOR OFFICE USE ONLY	
Physician or Supplier Signature				<i>ESF#</i>	<i>CLAIM CLERK</i>
				<i>CHECK DATE</i>	<i>CHECKED BY</i>
<i>Phone</i>			<i>Date</i>		

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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**

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

Submit a copy of an itemized paid bill.

(An itemized bill is one that shows the patient's name, date of service, the type of service rendered, and the physician's or supplier's tax identifying number).

IMPORTANT

All Health Benefit claims must be filed no later than (12) months after the date of discharge.

