STATEMENT OF CLAIM
FOR
BOCES EDUCATORS VISION CARE BENEFITS

Mail Claim Form To:
SELE-DENT, INC.
One Huntington Quadrangle
Suite 1S03
Melville, NY 11747

TO BE COMPLETED BY EMPLOYEE

1. Patient Name	2. Relationship to Employee Self Spouse Child Other ☐ ☐ ☐ ☐	3. Sex M F ☐ ☐	4. Patient Date of Birth Mo / Day / Year	5. If Full Time Student School City
6. Employee Name First Middle Last	7. Employee Soc. Sec. # - -	9. Name of Group Vision Program		
8. Employee Mailing Address		Employer (Company) Name and Address		
City State Zip				
10. Spouse's Name	Spouse's Date of Birth Mo / Day / Year	Spouse's Soc. Sec. # - -		
11.Are other family members employed? ☐ yes ☐ no Name Soc. Sec. # If yes, indicate		12. Name and address of employer in Item 11		
13. Is patient covered by another plan? Plan Name Union Local Group No. Name and Address of Carrier Yes ☐ No ☐				

I authorize any individual or organization to release any information to Sele-Dent, Inc. for any services or benefits received or payable to me or on my behalf.
Required Statement: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime."

Signature of Eligible Insured _____ Date _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize payment of vision benefits to undersigned physician or supplier for service described below.

Signature of Insured _____ Date _____

TO BE COMPLETED BY PROVIDER OF MATERIAL OR VISION CARE SERVICES

Optometrist / Ophthalmologist / Optician			What is patient's present degree of visual activity?
Mailing Address			Corrected_____ Uncorrected_____
City State Zip			If tinted glasses were furnished, were they specifically prescribed for medical reasons Yes_____ No _____
Soc. Sec. or T.I.N.	License No.	Phone # ( )	Please indicate reason_____

Diagnosis or Nature of Illness or Injury

Description of Services	Date of Service	Fee
Examination		
Single Vision Lenses		
Bifocal Lenses		
Trifocal Lenses		
Frame Only		

Description of Services	Date of Service	Fee
Contact Lenses		
Other Charges		
Total Charges		

I hereby certify that the services/materials as indicated have been provided.

Signature_____ Date _____