vision Group Insurance Form

Standard Insurance Company Employee Benefits / P.O. Box 82622, Lincoln, NE 68501-2622
Toll Free 800-547-9515 / Fax 402-467-7336 / Web standard.com

Part 1: To be completed by Employee

1. Patient's full name (first, middle initial, last)	2. Patient birthdate (MM/DD/YY) / /	3. Relationship to employee ☐ Self ☐ Spouse ☐ Child ☐ Other	4. Sex ☐ M ☐ F
5. Employee's full name (first, middle initial, last)	6. Employee's identification number	Employee's birthdate (MM/DD/YY) / /	
7. Employee's mailing address (street address or P.O. Box, City, State, ZIP) Email address:	8. THIS SECTION MUST BE COMPLETED WITH EACH CLAIM SUBMISSION ONLY IF THE CLAIM IS FOR A DEPENDENT CHILD AGE 19 OR OVER Is patient a full-time student? ☐ Yes ☐ No If Yes, name and address of school:		
9. Employer (company) name and address LUCAS COUNTY COMMISSIONERS	10. Group number 160-756316	Division number N/A	Certificate number N/A

Questions 11 and 12 must be completed with each claim submission.

11. Is patient covered by another vision plan? ☐ Yes ☐ No	Name and address of other carrier N/A	Policy number N/A	Name and address of other employer: N/A
12. Other employee/subscriber name	Employee/subscriber identification number	Date of birth (MM/DD/YY) / /	Relationship to patient

13. **I have reviewed the following treatment plan, and I authorize release of any information relating to this claim. I understand that I am responsible for all cost of treatment. I certify these statements to be true and complete to the best of my knowledge.** X ______________________ ____________ Signature (patient, or parent if minor) Date	Check one box only: 14A. ☐ **Please send payment to me OR** 14B. ☐ **Please pay provider below** X ______________________ ____________ Signature (insured person) Date

LUCAS COUNTY EMPLOYEES should complete the information above and mail to:

Employee Benefits
PO Box 82622
Lincoln, NE 68501-2622

OR FAX to:

402-467-7336

Please be sure to attach your receipt which must include:

- **Name of Office/Provider**
- **Address of Office/Provider**
- **Phone # of Office/Provider**
- **Description of Materials/Service e.g. Lens; Office Visit, etc.**
- **Date of Service**