

**CENTRAL UNITED LIFE INSURANCE COMPANY**  
**INVESTORS CONSOLIDATED INSURANCE COMPANY**  
**Claim Form**

CAUTION: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

PART A TO BE COMPLETED BY PATIENT (INSURED) IMPORTANT: ALL QUESTIONS MUST BE COMPLETED AND FORM SIGNED

Insured's Name		Policy No.	
Street Address	City or Town	State	Zip Code
Office Phone No.	Date of Birth	Marital Status	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>

IF A DEPENDENT CLAIM

Dependent's Name	Date of Birth	Relationship
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Are you entitled to an income tax exemption for this dependent? Yes  No

If child, is he/she employed? Yes  No  Name of employer \_\_\_\_\_

Sex: Male  Female  If child is over 19 years old, is child a full-time student? Yes  No

Name of school \_\_\_\_\_

Are you or your dependent entitled to benefits under: Any other vision plan? Yes  No  Medicare Yes  No

If yes, name of family member holding policy \_\_\_\_\_ Policy No. \_\_\_\_\_

Name and address of employer, union, association, school, etc., carrying other plan \_\_\_\_\_

Name and address of other insurance company \_\_\_\_\_

PLEASE SIGN AND DATE AUTHORIZATION

I accept this claim form and authorize release of information relating hereto. I certify the truth of all personal information contained above and that all the services listed above have been completed/delivered. I agree to be responsible for the applicable co-payment as detailed in my Group program, for any services indicated as rendered. I also agree to be responsible for any and all services which may be rendered but not eligible for coverage under my Group Program.

Patient (Parent or Subscriber Signature) \_\_\_\_\_ Date \_\_\_\_\_

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the Provider of the Vision Benefits for the services as described on this claim but not to exceed the scheduled amount of covered vision care expenses for these services.

Insured Person (Signature) \_\_\_\_\_ Date \_\_\_\_\_

**COMPLETE AND RETURN  
THIS FORM PROMPTLY**

Central United Life Insurance Company  
Investors Consolidated Insurance Company  
P.O. Box 925309  
Houston, TX 77292-5309

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**PART B TO BE COMPLETED BY PROVIDER**

Name \_\_\_\_\_ Mailing Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Soc. Sec. No. or E.I.N. \_\_\_\_\_ License No. \_\_\_\_\_ Phone No. \_\_\_\_\_

1. Is exam required as condition of employment? Yes  No       2. Is exam the result of occupational injury? Yes  No   
 3. Is exam the result of auto accident? Yes  No       4. Other accident? Yes  No

If Yes to 1, 2, 3 or above, give brief description and dates

EXAMINATION	Description	Date	Code	Fee	Plan Allowance	Patient Responsibility
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HAVE GLASSES BEEN PRESCRIBED? Yes  No

Description:  Single Vision    Bifocal    Trifocal      Date      Code      Fee      Plan Allowance      Patient Responsibility  
 Bifocal/Trifocal Style: \_\_\_\_\_

Prescription:

	Sphere	Cylinder	Axis	Prism	Base	Base Curve
R						
L						

	BIFOCAL ADD	Height	Width	PUPILLARY WIDTH:	Reading	Distance
R						
L						

FRAMES: Mfg. Name & Style: \_\_\_\_\_

HAVE CONTACT LENSES BEEN PRESCRIBED? Yes  No

Description:  Hard    Soft    Gas Permeable      Date      Code      Fee      Plan Allowance      Patient Responsibility  
 Extended Wear    Bifocal

Prescription:

Hard or Soft Daily Wear Contact Lenses

	Base Curves	Lens Rx	Lens Size	2nd Curve Width	P.C. Width	2nd. Curve Radius	P.C. Radius	O.Z.	Tint
R									
L									

Gas Permeable or Extended Wear Contact Lenses

	Lens Rx	Lens Size	Type or Mfg.	Add	Seg. Hgt.
R					
L					

BIFOCAL CCL.

Bifocal Style

RAM

- Crescent
- Curve Top
- One Piece

Manufacturer & Style #: \_\_\_\_\_

The services listed above are the only services considered for possible benefits under your vision care plan. Payment of these services is subject to current eligibility on the date services are completed/delivered.

I hereby certify that the services as indicated by the date listed have been completed/delivered and that the fees submitted are the actual fees charges and intended to be collected for these services. Payment is requested in accordance with the rules and regulations of The Health Application Network

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

PROVIDER signature Required