vision Group Claim Form

Ameritas Life Insurance Corp.

Return form with vision receipt to

Claim Office / P.O. Box 82520, Lincoln, NE 68501-2520 / Toll Free 800-255-4931 / Fax 402-467-7336 / Web ameritas.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)	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:
Email address:	

9. Employer (company) name and address	10. Group number	Division number	Certificate number

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	Policy number 9878760 (Postdoc)	Name and address of other employer:
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