



BCI ADMINISTRATORS, INC. P.O. BOX 250878 WEST BLOOMFIELD, MI 48325-0878
 Phone: 248-626-8896 Fax: 248-626-8185

CLAIM FOR VISION BENEFITS

EMPLOYER'S NAME _____

INSTRUCTIONS: 1. Complete, date and sign this form. 2. Include/attach all itemized bills/receipts.
 3. Mail or Fax to BCI Administrators, Inc. at the above address/Fax number

EMPLOYEE INFORMATION

First Name		M.I.	Last Name		Employee's SSN (last 4 digits)			
Address		City		State	Zip Code	Is this a new address? <input type="checkbox"/> Yes <input type="checkbox"/> No		
A	Date of Birth		Sex		Marital Status			
	Month	Day	Year	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated
Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Employment Terminated → Date of Termination _____								
Is this claim the result of an accident or occupational illness?					<input type="checkbox"/> Yes <input type="checkbox"/> NO	If Yes, complete section "C" below		
Are you (Employee) covered by another group benefit plan?					<input type="checkbox"/> Yes <input type="checkbox"/> NO	If Yes, complete section "D" below		

PATIENT INFORMATION - Complete only if patient is other than employee

Patient's First Name		M.I.	Last Name		Relationship	Date of Birth		Sex	
						Month	Day	Year	<input type="checkbox"/> Male <input type="checkbox"/> Female
If Child, is she/he married?		If child, 19 or older?		If yes, dependent child is:		If yes, name of school/employer			
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Employed full time <input type="checkbox"/> Student full time					

ACCIDENT/OCCUPATIONAL CLAIM INFORMATION - Complete only if claim is a result of an accident or occupational illness-injury

Is claim due to an accident?		Date of accident		Description of accident (how & where)				
<input type="checkbox"/> Yes <input type="checkbox"/> No		Month	Day	Year				
C Describe occupational illness								

FAMILY/OTHER COVERAGE INFORMATION - complete if claim is for a dependent and/or other coverage is in effect

Is spouse employed?		Spouse's Name		Spouse's date of Birth			Spouse's SSN (last 4 digits)				
<input type="checkbox"/> Yes <input type="checkbox"/> No				Month	Day	Year					
Name of spouse's employer and address				City	State	Zip	Spouse's Employer Tel No ()		Is patient employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
D Is patient covered by another group benefit plan?				Name of other company/organization providing benefits							
<input type="checkbox"/> Yes <input type="checkbox"/> No											
Policy Plan Number		Address of other organization providing benefits		Street		City	State	Zip			

EMPLOYEE/PATIENT CERTIFICATION AND RELEASE - Employee must sign all claims. Dependent patient must sign also, if not a minor.

I hereby apply for benefits and certify that the above information is complete, true and correct. I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request.

To all physicians and other medical professionals, hospitals and other medical care institutions, insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders or benefit plan administrators:

You are authorized to provide BCI Administrators, Inc. and any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on BCI Administrators, Inc.'s behalf, with information concerning medical care, advice, treatment or supplies provided the Patient, and any employment-related information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits.

EMPLOYEE'S SIGNATURE _____ DATE _____ DEPENDENT'S SIGNATURE - IF NOT A MINOR _____ DATE _____

Assignment of Benefits

I hereby authorize payment directly to the provider of group insurance benefits otherwise payable to me. I understand I am financially responsible to the attending physician for charges not covered by this authorization.

EMPLOYEE'S SIGNATURE _____ DATE _____