

J. J. Stanis and company, Inc.  
 100 Jericho Quad., Ste 101  
 Jericho, NY 11753  
 Telephone: 516 465 3900 Fax: 516 465 3920

**Statement of Claim  
 FOR  
 GROUP VISION CARE BENEFITS**

**TO BE COMPLETED BY THE MEMBER:**

PATIENT NAME:		RELATIONSHIP TO EMPLOYEE: SELF SPOUSE CHILD OTHER		Sex M F	Patient Date of Birth Month/Date/Year / /	If Full Time Student: School/City
Employee Name: First Middle Last			Employee SSN / /		Name of Group Vision Program	
Employee Mailing Address				Employer (Company) Name and Address		
City, State, Zip						
Spouse's Name		Spouse's Date of Birth Month/Date/Year / /		Spouse's ID  Social Security Number / /		
Are other family members employed? Name		____ Yes ____ No Social Security Number		Name and address of employer		
If Yes, Indicate						
Is Patient Covered by another Plan? ____ Yes ____ No		Plan Name		Union/Local		Group Number Name and Address of Carrier

I authorize any individual or organization to release any information to J. J. Stanis and Company Inc. and/or CBCA for any services or benefits received or payable to me or on my behalf.  
 REQUESTED 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 MATERIALS OR VISION CARE SERVICES**

Optometrist/Ophthalmologist/Optician:			I HEREBY CERTIFY THAT THE SERVICES/MATERIALS AS INDICATED HAVE BEEN PROVIDED  SIGNATURE: _____  DATE: _____		
Mailing Address:					
City/State/Zip:					
SSN or Tin:	License No	Phone No ( ) -			
Diagnosis or Nature of Illness or Injury:					
Description of Services	Date	Fee	Description of Services	Date	Fee
Examination			Contact Lenses		
Single Vision Lenses			Other		
Bifocal Lenses					
Trifocal Lenses					
Frame Only			TOTAL CHARGES		

To access additional claim forms, please visit our website: [www.jjstanisco.com](http://www.jjstanisco.com)