



**STATEMENT OF CLAIM
FOR
GROUP VISION CARE BENEFITS**

TO BE COMPLETED BY THE EMPLOYEE:

1. Patient Name		2. Relationship to employee	3. Sex	4. Patient birth date	5. If full time student; School	City
6. Employee Name; First Middle Last		7. Employee SOC..SEC. NO.		8. Group Name MINISINK VALLEY TEACHERS ASSOCIATION BENEFIT TRUST FUND		
9. Employee Mailing Address				10. Company Name and Address Minisink Valley Central School District Route 6 Slate Hill, N. Y. 10973		
11. City, State Zip						
12. Is Patient Covered by Another Plan?	Plan Name	Union Local	Group No.	Name and Address of Carrier		
<input type="checkbox"/> YES <input type="checkbox"/> NO						

I authorize any individual or organization to release any information to Preferred Group Plans, Inc. for any services or benefits received or payable to me or on my behalf.

REQUIRED 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 materials thereto, commits a fraudulent insurance act, which is a crime."

Signature of Eligible Insured _____ Date _____

Attach the ***original receipt** and mail with the completed claim form to: **Preferred Group Plans
P.O. Box 15136
Albany, NY 12212-5136
Attn: Claims Dept.**

- * Original Receipt must include the following:
- 1.) Name of the patient.
 - 2.) Name of the provider.
 - 3.) Date of service.
 - 4.) Description of services rendered.