



SVS VISION
PREPAID VISION CARE PROGRAM
APPLICATION FOR BENEFITS
(PLEASE PRINT CLEARLY AND SIGN BELOW)

EMPLOYEE INFORMATION

1. EMPLOYEE LAST NAME		2. EMPLOYEE FIRST NAME		3. MID INT
4. EMPLOYEE STREET ADDRESS				
5. CITY	6. STATE	7. ZIP CODE	8. SOCIAL SECURITY NUMBER	

PATIENT INFORMATION

9. PATIENT'S LAST NAME		10. PATIENT'S FIRST NAME		11. MID INT	12. SEX Male ___ Female ___	13. DATE OF BIRTH
14. RELATIONSHIP TO EMPLOYEE Self ___ Spouse ___ Dependent ___		15. OTHER INSURANCE CARRIER/PLAN? IF YES, INDICATE CARRIER/PLAN AND POLICY NUMBER YES ___ NO ___				
16. WERE SERVICES CONNECTED WITH PATIENT'S EMPLOYEMENT? YES ___ NO ___		17. WERE SERVICES PERFORMED BY A SVS/AFFLIATED PROVIDER YES ___ NO ___				
18. ADDITIONAL INFORMATION						

19. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND THE ATTACHED MATERIAL IS CORRECT AND UNALTERED. I UNDERSTAND THAT ALL MATERIAL SUBMITTED BECOMES THE PROPERTY OF SVS VISION AND HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL INFORMATION REGARDING VISION CARE SERVICES RECEIVED UNDER THE SVS PREPAID VISION CARE PROGRAM TO SVS OR THOSE DESIGNATED BY SVS.

EMPLOYEE SIGNATURE _____ DATE _____ AREA CODE TELEPHONE NUMBER _____

SERVICE INFORMATION

20. SERVICE LINES	A. DATE OF SERVICE	B. LOC	C. TYPE	D. PROCEDURE	E. TOTAL CHARGE	F. EMPLOYEE LIABILITY	G. EXPL CODE
1			M				
2			M				
3			M				
4			M				
5			M				

21. TOTAL SERVICE LINES		22. TOTAL CHARGES		
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PROVIDER INFORMATION

23. LICENSE NUMBER	24. SP	25. PROVIDER NAME		
26. PROVIDER ADDRESS		27. CITY	28. STATE	29. ZIPCODE

DOCUMENT NUMBER-DO NOT WRITE IN THIS AREA
PROVIDER IDENTIFICATION (OTHER THAN FORD MOTOR COMPANY)

I CERTIFY THE SERVICES HEREIN WERE PERFORMED BY ME OR UNDER MY DIRECT AND PERSONAL SUPERVISION AND IN MY PRESENCE.
PROVIDER SIGNATURE _____ DATE _____

Approval Number