I hereby authorize this vision care provider to apply for benefits on my behalf for covered services rendered by them. I also assign my benefits and request that all payments from _____ be made directly to the vision care provider. I agree to assume responsibility for full payment pending any remaining balance that is not covered by _____.

I certify that the information I have reported with regard to my coverage is correct. I further authorize vision care provider to release to _____ and its agents any information related to this or any related claim.

_____

Member's Signature and Date

_____

Printed Name of Member

_____

If member under age 18, signature of responsible party and Date