Guardian Group

Guardian Life of The Caribbean Limited

GUARDIAN LIFE OF THE CARIBEBAN LITD
ASSIGNMENT OF VISION CARE BENEFIT PROVIDER FORM

FROM: ………………………………………………………… FAX: …………………………

TO: …………………………………………………………….. FAX: ………………………….

INSURED: ……………………………………………………………………………………

DEPENDANT: ……………………………………………………………………………........

EMPLOYER: …………………………………………………………………………………

TYPE OF SERVICE	ACTUAL COST	AMOUNT RECOVERABLE	PATIENT LIABILITY
Examination:	$_____________	$ ________________	
Lenses (Type)	$ _____________	$ ________________	
Frames:	$ _____________	$ ________________	
TOTAL :	$ _____________	$ ________________	$ _______________

________________________ Optometrist's Signature

_____________________ Date

________________________ GLOC Representative

_____________________ Date

ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY AUTHORISE PAYMENT directly to the above named company of the Vision Care Benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization OR should my claim for insurance coverage not be successful for any reason.

NB. Your entitlement to Vision Care: Eye Exam – I every 12 month period
Lenses- 1 pair every 12 month period

Frames - 1 paid every 24 month period

Signature of Insured Employee ____________________ Date ____________________