



Looking After Life
A Member of the Guardian Holdings Group

GUARDIAN LIFE OF THE CARIBBEAN LTD. – HEALTH OPERATIONS
ASSIGNMENT OF VISION CARE BENEFIT PROVIDER FORM

FROM: \_\_\_\_\_

FAX#: \_\_\_\_\_

622-1202 or 628-4923

TO: \_\_\_\_\_

FAX#: \_\_\_\_\_

INSURED: \_\_\_\_\_

DEPENDANT: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

Table with 4 columns: TYPE OF SERVICE, ACTUAL COST, AMOUNT RECOVERABLE, PATIENT LIABILITY. Rows include Examination, Lenses (Type), Frames, and 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- 1 every 12 month period
Lenses- 1 pair every 12 month period
Frames- 1 pair every 24 month period

Signature of Insured Employee:

Date