Mail this form to:
EBS-RMSCO, Inc.
P.O. Box 4863
Syracuse, NY 13221-4863

For information please call:
1-800-803-5773 Toll Free
(315) 671-9894 Local Calls

Group Vision Claim Form

<table>
<tr><td colspan="2">Member Identification No.</td><td>Group #</td><td colspan="3"></td></tr>
<tr><td colspan="3">Patient Name (First, Middle, Last)</td><td>Relationship to Employee
Self ❑ Spouse ❑ Child ❑ Other ❑</td><td>Sex
M ❑ F ❑</td><td>Patient Birth Date
MO / DAY / YEAR</td></tr>
<tr><td colspan="3">Employee name (First, Middle, Last)</td><td colspan="3" rowspan="2">Employer Name and Address</td></tr>
<tr><td colspan="3">Employee Mailing Address</td></tr>
<tr><td colspan="3">City, State, Zip</td><td colspan="3">Was condition related to?
Employment ❑ Yes ❑ No Auto Accident ❑ Yes ❑ No</td></tr>
<tr><td colspan="6">Is patient covered by another plan? ❑ Yes ❑ No   If yes, name of other plan: Group No.   Name and address of carrier</td></tr>
<tr><td colspan="6">Has bill been paid by you? ❑ Yes ❑ No   Symptoms of Diagnosis   Date and time symptoms started or accident occurred</td></tr>
</table>

Before signing claim form, please read the following.
Failure to submit a claim form without the information listed below will result in the claim being returned to you.

1. In order for this claim to be processed, an itemized bill must be attached and include:
   - The provider's name and address (hospital, Dr's, lab, pharmacy, etc.)
   - The date(s) of service.
   - The patient's name.
   - Charges listed for each service.
   - Prescription receipts must include the prescription number, physician and name.
   - Diagnoses or symptoms.
2. If another insurance carrier or medicare had made payment on this service, their explanation of benefits form must be attached.
3. Only one patient may be included on a claim form.
4. There is no limit to the amount of bills you may attach to the claim form.
5. It is recommended that you keep copies of information submitted to EBS Benefit Solutions for your records.

Signature of Contract Holder ______________________________________ Date _________________________

Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or conceals, for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.