FIDELITY SECURITY LIFE INSURANCE COMPANY

CLAIM VERIFICATION FORM

MAIL TO: Fidelity Security Life Insurance Company
c/o FORREST T. JONES CONSULTING COMPANY
3130 Broadway, P.O. Box 418131
Kansas City, MO 64141-9131

COAST TO COAST 20/20 SELECT VISION PLAN

PROVIDER INFORMATION

Provider		Coast To Coast I.D. Number
Address		
City	State	Zip
Telephone Number		Taxpayer I.D. Number

PATIENT INFORMATION

Employee Name		Certificate Number
Patient Name		
Address		
City	State	Zip
Telephone Number		Employer Name

BENEFITS

Date of Service	
Exam Fee Amount	Exam Co-Pay Amount

Materials Dispensed	Retail Price	Coast To Coast Discounted Price
Eyeglasses (Frame, Lens and Add-ons)	$____________	$____________
Contact Lenses	$____________	$____________
	Less Materials Co-Pay (Due From Patient)	$____________
	Less Insurance Coverage (Maximum up to $125.00 Less Co-Pay)	$____________
	Materials Balance Amount (Due From Patient)	$____________

NOTE TO ALL PARTIES COMPLETING THIS FORM: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

When the CTC Discounted Price on Materials Dispensed is less than the maximum benefit, insurance will pay the lesser amount (less Co-Pay).

The undersigned hereby certifies the above-mentioned exam and materials were purchased on the date of service stated above.

Provider Signature	Patient Signature