Custom Design Benefits

New Riegel Local School District
Vision Care Claim Form

Submit Claims To:
Custom Design Benefits,
5589 Cheviot Road
Cincinnati, OH 45247
Ph: (513) 598-2929
800-598-2929
Fax: (513) 389-2998

Please type or print neatly. Use one form for each provider.

Employee Name	SS#
Address	Phone #
City/State	Zip

Claimant Name	Claimant Birth date
Relationship to Employee: Self Spouse Child Dependent	
Is Claimant a Student? Yes No	
Is Claimant Covered under another Plan? Yes No	
If yes, please provide other carrier name, address, phone and group #:	

Item/Service	**Amount Paid**
Eye Examination (one every 12 months)	
Frames ($120 max benefit once every 24 months)	
Lenses (one every 12 months, contacts $105 max benefit once every 24 months) Circle lense type: Single Vision Bi-Focal Tri-Focal Contacts	

Provider Name	Service Date
Address	Phone #
City/State	Zip

I certify that the information reported above and attached to this claim form is accurate to the best of my knowledge and is for optical services or materials for my personal use or the personal use of a covered claimant under this Plan.

_____ _____

Employee Signature Date

Please attach detailed receipt from Vision provider for services performed to this claim form.