Southland Benefit Solutions
P.O. Box 1250
Tuscaloosa, Alabama 35403
1-205-951-4455
www.southlandbenefit.com

VISION CLAIM FORM

Claims must be received within 365 days of the date of service.

ID Card Contract Number _____ Group # 2500

Member's Name (Last, First, Middle Initial) _____

Member's Date of Birth _____ Member's Gender ☐ Male ☐ Female

Member's Address, City, State, Zip Code _____

Member's Cell Number (Include area code) _____

Patient's Relationship to Member: ◯ Self ◯ Spouse ◯ Child ◯ Other

If the relationship is anything other than self, complete the patient information below:

Patient's Name (Last, First, Middle Initial) _____

Patient's Date of Birth _____ Patient's Gender ☐ Male ☐ Female

Patient's Cell Number (Include area code) _____ Patient's Email: _____

Please indicate the benefit and date of service requested:

Claim	Annual Benefit (actual charges not to exceed)	Date of Service or Purchase
Examination	$95	
AND		
Frames	$95	
Single Vision Lenses	$100	
Bifocal Lenses	$130	
Trifocal Lenses	$180	
Lenticular Lenses	$180	
OR		
Contacts	$180	
OR		
Refractive Surgery	$180	

Note Limitations: Only One per Plan Year (Jan 1 – Dec 31)

- Examination
- Contacts – One new prescription or replacement, **or**
- Frames and Lenses – One new or replacement frame and one new lens prescription or replacement, **or**
- Refractive Surgery – One surgery per eye

Mail completed request, including itemized receipts of purchase, a copy of the prescription, and any other supporting documentation to the address above.