



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

<u>Materials Dispensed</u>	<u>Retail Price</u>	<u>Coast To Coast Discounted Price</u>
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
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