



WEA Administrators
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 Cooper City, Florida 33026 USA

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 Email info@wwexpa.com

IMPORTANT: PLEASE READ INSTRUCTIONS CAREFULLY Complete all relevant sections of this Claim Form. A separate Claim Form must be completed for each individual making a claim, however multiple vision expenses can be claimed on a single form. Original documentation (itemized bills and receipts) must be submitted with the Form. Photocopies of documents are NOT acceptable.

A. GENERAL INFORMATION (TO BE COMPLETED BY THE INSURED PERSON) (please print)

1. Insured's Name (Last, First, MI) <input type="text"/>	2. Alias Name(s) <input type="text"/>
3. Birth Date: (MM/DD/YR) <input type="text"/>	4. WEA Policy Number <input type="text"/>
5. Patient's Name (Last, First, MI) <input type="text"/>	6. Alias Name(s) <input type="text"/>
7. Birth Date: (MM/DD/YR) <input type="text"/>	8. Relationship to Insured <input type="text"/>
9. Home Country <input type="text"/>	10. Country of Assignment <input type="text"/>
11. Mailing Address (Home Country) <input type="text"/>	12. Mailing Address (Country of Assignment) <input type="text"/>
13. Phone Number (Home Country) <input type="text"/>	14. Phone Number (Country of Assignment) <input type="text"/>
15. E-mail Address <input type="text"/>	
16. Is There Another Vision Benefit Plan? Yes <input type="checkbox"/> No <input type="checkbox"/>	

B. ASSIGNMENT OF BENEFITS

17. Assignment: Please pay provider directly to the address indicated on the attached original provider invoice. Yes No

18. Insured's Signature

19. Date Signed

C. AUTHORIZATION TO RELEASE INFORMATION

I certify that the above statements are true and correct to the best of my knowledge and hereby authorize any physician, hospital, employer, union, insurance company, HMO, or prepayment organization to supply each other any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

20. Insured's Signature

21. Date Signed

D. FRAUD WARNING

Any person, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, who submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

E. PHYSICIAN OR SUPPLIER INFORMATION (TO BE COMPLETED BY VISION CARE PROVIDER)

Please complete for claims greater than US\$ 300.00

Optometrist/Ophthalmologist/Optician Name

Address Diagnosis or Description of Condition

Phone Number Did Prescription Change for: Right Eye Left Eye
First Visit Date (MM/DD/YY) Cost of Examination

Were contact lenses prescribed for severe corneal astigmatism, corneal scarring, keratoconus or aphakia? Yes No

Can visual acuity be improved by up to at least the 20/70 level by spectacle lenses? Yes No

Can visual acuity be improved by up to at least the 20/70 level by contact lenses? Yes No

Signature of Optometrist/Ophthalmologist/Optician First Visit Date (MM/DD/YY)

Optical Supplies Furnished By

Address Laboratory Cost of Lenses
Laboratory Cost of Lenses
Laboratory Cost of Lenses

Phone Number

Specify Type of Lenses: Single Multifocal Bifocal Lenticular Specify Tone Light: 1 2 3

Hardex/Safety Material

Are these prescription sun glasses? Yes No Photogrey/Photosun

Replacement of lost or damaged glasses? Yes No

Other, Please Specify

Signature of Optometrist/Ophthalmologist/Optician First Visit Date (MM/DD/YY)

NOTES