Custom Design Benefits

City of Oakwood
Vision Plan Claim Form

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

Please type or print neatly. Use one form for each provider. Attach your itemized receipts to this form.

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 #:

Is banking information already on file for reimbursement? Yes No
If no, please complete page two. Reimbursement can only be sent by Direct Deposit; checks are not available.

Item/Service	**Amount Paid**
Examination	
Frames	
Lenses (indicate type of lens below)	
Total	

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

Plan:
ID:

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AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

I. Authorization

The member authorizes Custom Design Benefits (through ECHO Health Inc.) to directly deposit benefits payable to the member into the account specified below for Flexible Spending and/or Short-Term Disability and Medical/Dental. Please be aware that direct deposit setup will result in all payments to the member to directly deposit into your account, including payments for Medical/Dental/Vision claims where we are not authorized to pay the servicing provider. If you then owe that amount to the provider, you will be responsible for forwarding payment to the provider.

II. Activation

Setup requires (7) business days from the date of receipt to activate.

III. Documentation Requirements

The account specified below must be held by the member. A voided check must be provided with this form. We cannot accept copies of deposit slips.

IV. Termination of Authorization

This authorization remains in effect until such time as the member notifies Custom Design Benefits in writing to terminate direct deposit procedures, ceases to be eligible for benefits under their plan or returns to work from disability status. In the event of a new period of disability, a new agreement form would then be required at Custom Design Benefits discretion.

V. Changes to Account Information

It is the member's responsibility to notify Custom Design Benefits of any changes/updates to the banking information given on this form, or changes of email address. All changes/updates must be in writing and dated, and require up to seven (7) business days from receipt to activate.

VI. Notification of Deposit

By providing an email address the member authorizes all notifications of deposit to be delivered to this email address instead of postal mail. If you do not provide an email address, notification of deposit will be sent via regular postal mail.

I hereby authorize direct deposit to my checking account pursuant to the above stipulations:

Member Signature: _____ Date: _____

☐ I have attached a voided check for my checking account (not a deposit slip)

Account Holder: _____ Email: _____

Bank Name: _____ Checking/Savings: _____

Bank Routing Number: _____ Account Number: _____

ECHO HEALTHCARE PAYMENT SYSTEMS