# SELF-REPORT FORM: MATERNITY BENEFIT

## Has Your Vision Changed During Pregnancy and/or Breastfeeding?

Your plan offers a Maternity Benefit which provides additional coverage to pregnant or breastfeeding women who may experience vision changes. In order to use this benefit you will need to first utilize your standard benefits during your Plan Year. Once you've used your standard benefits, you can then complete this form and submit to Surency to access your additional benefits outlined below. Your plan's copay will apply, like usual, for both the additional exam and lenses.

## Our Maternity Benefit Includes:

- **An Additional Eye Exam Coverage**
  With your Surency Vision Maternity Benefit, you can receive coverage for a second eye exam during your Plan Year.
- **Additional Lenses**
  If your prescription changes 0.5 diopter or more, you are eligible for additional lenses.

***Please note: This benefit is only applicable if your vision has changed during your pregnancy and/or breastfeeding stage. Your standard benefits will be reset to match that of your group benefit coverage on Jan. 1st each year. If your pregnant/breastfeeding status continues into the new year, please fill out this form again to obtain the additional Maternity Benefit coverage for the new year.***

## Member Information

Member Name: ______________________________

Employer: ______________________________

Home Address: ______________________________

City, State, ZIP: ______________________________

Surency Vision Member ID#: ______________________________
*(Social Security Number or Member ID Number)*

Please select which of the following applies to you:

☐ Pregnant - Estimated Due Date: _____ / _____ / _________

☐ Breastfeeding

Please allow 10 business days for your enhanced benefits to be effective.

## Signature

By signing below, I am confirming that the above information is true and correct, and that by completing this form, I am indicating a status that I am either pregnant or breastfeeding for the purpose of Surency Vision providing the Maternity Benefit plan. Surency reserves the right to obtain information from my treating physician to confirm the status indicated above.

Signature: ______________________________ Date: ______________

**Return completed form back to Surency at email: eligibility@surency.com**
**or mail: P.O. Box 789773, Wichita, KS 67278-9773**

**800-264-9462 • Surency.com**

Surency Vision is administered by Surency Life & Health Insurance Company.
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