Slovene
National
Benefit
Society

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Application for Disability for Loss of Eye or Eyesight

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Name_____ Lodge #_____

☐ Male ☐ Female Date of Birth _____ Policy # _____

Address_____

Signature of Insured _____

Office Use Only

☐ Approved _____

☐ Disapproved _____

OPHTHALMOLOGICAL EXAMINATION

Name of Claimant _____ Date of Examination _____
Address
_____

PAST HISTORY

Does the claimant have or has he/she ever had tuberculosis, diabetes, Bright's disease, syphilis, or hypertension?
Yes _____ No _____ If yes, explain _____
Duration of disease and present complaints _____
_____
Eye disease and duration_____
Date of injury or disease_____
Previous history_____
Was the claimant at the time of injury under the influence of liquor, narcotics or tranquilizers? Yes ____ No ____
What other sickness or injury has contributed toward present injury or inflammation of eye?
_____

EXAMINATION AND FINDINGS

1. **VISION:**
   a) Visual accuity measurement
      OD 20/_____
      OS 20/_____
   b) Legally Blind
      Yes _____
      No _____
   c) Totally Blind
      Yes _____
      No _____
2. **CORNEA:**
   a) Shape _____
   b) Smoothness _____
   c) Transparency _____
3. Depth and contents of interior chamber, if any _____
4. **PUPIL:**
   a) Size _____
   b) Shape_____
   c) Reaction of light and accommodation _____
5. Lens transparency_____
6. Vitreous transparency_____
7. Funds lesions, if any_____
8. Intraocular tension _____
9. Additional facts and remarks, if any _____
   _____
10. In your professional judgment, is this patient disabled based on their vision? Yes _____ No _____

I hereby certify that my answers to the foregoing questions are correct and true to the best of my knowledge and belief without any evasion or reservations.

Doctor's Signature _____ Date_____

Printed Name of Doctor _____ Phone # _____

Doctor'sAddress_____