

# TAXSAVER PLAN

## *I2 Technologies Vision Claim Form*

\_\_\_\_\_  
Employee Last Name/First Name (please print)      Social Security Number      Date of Birth

\_\_\_\_\_  
Street Address      City/State      Zip

\_\_\_\_\_  
Patient Name (if other than employee)      Date of Birth      Relationship

**Total Charges**      \$ \_\_\_\_\_

**Date of Service**      \_\_\_\_\_

\_\_\_\_\_  
**Yes, should my vision expenses exceed \$200.00, please submit the remaining eligible expenses to my Health Spending Account which I have elected with I2.**

I certify that I will not submit these expenses for payment to any other third party such as an insurance company. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable by law and may be subjected to civil penalties.

\_\_\_\_\_  
Date      Employee Signature

**Documentation Required: Please attach statement from provider.**

- Itemized receipts must show dates of service, cost of service, name of provider and type of service provided.
- Attach copies of your bills to this completed claim form and send them to Tax saver Plan
- Keep a copy for your records

**Submit Claim To:**      Tax saver Plan  
P.O. Box 609002  
Dallas, Texas 75360  
800-328-4337 – [www.taxsaverplan.com](http://www.taxsaverplan.com)  
214-528-8122 Fax  
[claims@taxsaverplan.com](mailto:claims@taxsaverplan.com) - attach jpeg, tiff or jif files. (please do not scan at a high resolution)