

V I S I O N C A R E C L A I M

**Please print clearly.** Use this form to claim Vision Care benefits only. Your plan covers corrective eyeglasses, contact lenses, and laser eye surgery, up to the maximum amount payable and frequency restrictions in your firm's plan. **All the information you provide on this form will be treated as confidential.**

- The employee completes Sections A and B. Please provide all the information requested.
- Sections C and D are optional, completed only when the employee wants the plan benefits paid directly to the service provider.
- **Send us an original, itemized receipt, unless the employee completes Section C.** For assigned benefits, all we need is the completed claim form.
- Send the claim to the Plan Administrator at: **Chambers of Commerce Group Insurance Plan, 582 King Edward Street, Winnipeg, Manitoba R3H 0P1**

■ ■ ■  
**A. EMPLOYEE DATA**

Employee's Last Name \_\_\_\_\_ Employee's Given Name(s) \_\_\_\_\_  
 Employee's Full Mailing Address \_\_\_\_\_  
 Patient's Last Name (if other than the employee) \_\_\_\_\_ Patient's Given Name(s) \_\_\_\_\_  
 Patient's Date of Birth (D/M/Y) \_\_\_\_\_

■ ■ ■  
**B. EMPLOYEE'S DECLARATION**

- |  |   |
|--|---|
| <p>1. The vision correction was prescribed by the patient's<br/> <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Optometrist <input type="checkbox"/> Physician</p> <p>2. This purchase was made on (D/M/Y) _____</p> <p>3. The total amount of the purchase was \$ _____</p> <p>4. Are you eligible for any other vision care insurance benefits or services?<br/> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>5. If you answered YES to question 4, please provide the following.</p> <p>Insured/Employee's Full Name _____</p> <p>Date of Birth (D/M/Y) _____ Relationship to You _____</p> <p>Employer's Name _____</p> <p>Group Policy _____</p> <p>Group Insurer _____</p> |
|--|---|

I authorize the release of any information or record requested in respect of this claim, and certify that the information provided on this form is true, correct and complete to the best of my knowledge.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

■ ■ ■  
**C. ASSIGNMENT OF BENEFITS**

*Complete this section **only** if you want the benefits payable sent directly to your service provider. (Supplier must complete Section D.)*

I hereby assign benefits to the following supplier. I understand that the charges listed on this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to the above supplier for the costs I have incurred here.

Supplier's Name \_\_\_\_\_  
 Employee's Signature \_\_\_\_\_ Full Mailing Address \_\_\_\_\_

■ ■ ■  
**D. SUPPLIER'S REPORT**

- |   |                 |           |            |          |           |          |       |          |              |                 |   |             |          |           |               |       |       |         |       |       |          |       |       |         |       |       |
|---|-----------------|-----------|------------|----------|-----------|----------|-------|----------|--------------|-----------------|---|-------------|----------|-----------|---------------|-------|-------|---------|-------|-------|----------|-------|-------|---------|-------|-------|
| <p>1. Date of Service (D/M/Y) _____</p> <p>2. Charges</p> <table border="0"> <tr> <td>Frames</td> <td>\$ _____</td> </tr> <tr> <td>Right Lens</td> <td>\$ _____</td> </tr> <tr> <td>Left Lens</td> <td>\$ _____</td> </tr> <tr> <td>Other</td> <td>\$ _____</td> </tr> <tr> <td><b>TOTAL</b></td> <td><b>\$ _____</b></td> </tr> </table> | Frames          | \$ _____  | Right Lens | \$ _____ | Left Lens | \$ _____ | Other | \$ _____ | <b>TOTAL</b> | <b>\$ _____</b> | <p>3. Types of lenses</p> <table border="0"> <tr> <td>Plain glass</td> <td>Left Eye</td> <td>Right Eye</td> </tr> <tr> <td>Single vision</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Bifocal</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Trifocal</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Contact</td> <td>_____</td> <td>_____</td> </tr> </table> | Plain glass | Left Eye | Right Eye | Single vision | _____ | _____ | Bifocal | _____ | _____ | Trifocal | _____ | _____ | Contact | _____ | _____ |
| Frames  | \$ _____        |           |            |          |           |          |       |          |              |                 |   |             |          |           |               |       |       |         |       |       |          |       |       |         |       |       |
| Right Lens  | \$ _____        |           |            |          |           |          |       |          |              |                 |   |             |          |           |               |       |       |         |       |       |          |       |       |         |       |       |
| Left Lens   | \$ _____        |           |            |          |           |          |       |          |              |                 |   |             |          |           |               |       |       |         |       |       |          |       |       |         |       |       |
| Other   | \$ _____        |           |            |          |           |          |       |          |              |                 |   |             |          |           |               |       |       |         |       |       |          |       |       |         |       |       |
| <b>TOTAL</b>  | <b>\$ _____</b> |           |            |          |           |          |       |          |              |                 |   |             |          |           |               |       |       |         |       |       |          |       |       |         |       |       |
| Plain glass   | Left Eye        | Right Eye |            |          |           |          |       |          |              |                 |   |             |          |           |               |       |       |         |       |       |          |       |       |         |       |       |
| Single vision   | _____           | _____     |            |          |           |          |       |          |              |                 |   |             |          |           |               |       |       |         |       |       |          |       |       |         |       |       |
| Bifocal   | _____           | _____     |            |          |           |          |       |          |              |                 |   |             |          |           |               |       |       |         |       |       |          |       |       |         |       |       |
| Trifocal  | _____           | _____     |            |          |           |          |       |          |              |                 |   |             |          |           |               |       |       |         |       |       |          |       |       |         |       |       |
| Contact   | _____           | _____     |            |          |           |          |       |          |              |                 |   |             |          |           |               |       |       |         |       |       |          |       |       |         |       |       |
4. Describe any "Other" charges, including itemized costs. \_\_\_\_\_
5. If you provided tinted lenses, what kind of tint was used? \_\_\_\_\_
6. What is the nature of the patient's visual impairment? \_\_\_\_\_
7. Prescribing Optometrist's or Ophthalmologist's name. \_\_\_\_\_
8. I certify that I am a legally qualified  Ophthalmologist  Optometrist  Optician and that the services listed above are correct and represent those provided to the named patient.

Signed \_\_\_\_\_ Date \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_