SEND FORM TO:

Great-West Life Health & Dental Benefits
P.O. Box 3050
Winnipeg, Manitoba R3C 4E5
1-800-957-9777
(204) 942-3589

THE
Great-West Life
ASSURANCE COMPANY

VISIONCARE
CLAIM FORM

INSTRUCTIONS Complete a separate form for each family member for whom you are claiming expenses. Attach bills for each expense and fully itemize them in the space provided below.

IMPORTANT **If any of the requested information is missing or incorrect, your claim will be returned**

NAME OF GROUP **TRUSTEES OF THE WELFARE FUND, I.B.E.W. LOCAL 353** POLICY NUMBER **51189**

EMPLOYEE'S NAME ______

EMPLOYEE'S ADDRESS ______ ______ POSTAL CODE

EMPLOYEE ID NUMBER ______ DIVISION NUMBER ______

PREFERRED LANGUAGE OF COMMUNICATION: ☐ FRENCH ☐ ENGLISH

NAME OF PATIENT ______ DATE OF BIRTH ___/___/___ (DAY MONTH YEAR) ______ RELATIONSHIP TO EMPLOYEE

1. If Dependent, does the patient reside with you? ☐ Yes ☐ No
2. If child 18 years or order
   - A. FULL-TIME STUDENT? ☐ Yes ☐ No
   - B. If student, how many hours per week at school? ______
   - C. EMPLOYED ☐ Yes ☐ No If Yes, how many hours worked per week?

3. Are you or any member of your family entitled to benefits under any other Group Insurance? ☐ Yes ☐ No

   If yes, name of family member insured ______

   Name and address of other

   Insurance Company ______ Policy No. ______

4. Is any member of your family (other than yourself) insured as an employee under this policy? ☐ Yes ☐ No

   If Yes, Name of family member ______

5. If Yes to question 3 or 4 above, and patient is a dependent child, give employee's birth date ______ (DAY MONTH)

   AND spouse's birthday ______ (DAY MONTH)

TO BE COMPLETED BY PROVIDER OF MATERIALS

1. Date of Service: ______

CHARGES FOR MATERIALS SUPPLIED:	
Frames	$
Lens for right eye	$
Lens for left eye	$
Other	$
TOTAL	$

2. Type of lenses supplied

	Left Eye	Right Eye
Plain Glass		
Single Vision		
Bifocal		
Trifocal		
Contact		

3, Reason for purchase (please check)

a) Initial prescription ______
b) Prescription change ______
c) Lost or breakage ______
d) Other (please explain) ______

4. Give reasons and specific item cost for "Other in area 1. eg. Hardening, tinting, varigray, oversize lenses, etc.

   If glasses tinted, what was tint?

5. Name of Prescribing Optometrist or Ophthalmologist – if signed by Optician

I am a legal qualified ☐ OPHATHALMOLOGIST ☐ OPTOMETRIST ☐ OPTICIAN

SIGNED ______ DATE ______ TELEPHONE# ______

ADDRESS ______

Personal information we collect from you is kept in strict confidence and will be used to assess your claim and to administer the group benefit plan. I authorize the use of my Social Insurance Number as an identification number where it is required in the administration of my group benefit plan. I authorize Great-West, any healthcare provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with Great-West to exchange information when necessary to assess my claim and to administer the group benefit plan. I certify that the information given is true, correct and complete to the best of my knowledge.

EMPLOYEE'S SIGNATURE ______ DATE ______

A46-07182003