CARPENTERS' AND MILLWRIGHTS' HEALTH & WELFARE BENEFIT TRUST FUND OF SASKATCHEWAN

VISION CLAIM FORM

INSTRUCTIONS: Use a separate form for each family member. Attach the original receipts for all expenses. Receipts will not be returned, as a copy of the Explanation of Benefits is sent to you and copies of receipts are sufficient for income tax purposes or coordination of benefits with other group plans.

Your claim will be returned to you if the claim form is incomplete.

1. MEMBER INFORMATION

GROUP NUMBER	CERTIFICATE/SIN NUMBER		
3942			
LAST NAME	**FIRST NAME**		
ADDRESS	**GENDER** ☐ Male ☐ Female	**LANGUAGE** ☐ English ☐ French	**DATE OF BIRTH** (MM/DD/YY)
CITY	**PROVINCE**	**POSTAL CODE**	**PHONE NUMBER**

2. PATIENT INFORMATION

PATIENT NAME	RELATIONSHIP TO MEMBER	PATIENT DATE OF BIRTH (MM/DD/YY)

If Dependent, does the patient reside with you? ☐ Yes ☐ No

If child 18 years of age or older a) Full-time student? If yes, how many hours per week at school? _____ ☐ Yes ☐ No

b) Employed? If yes, how many hours per week? _____ ☐ Yes ☐ No

3. COORDINATION OF BENEFITS

Are you or any other member of your family entitled to benefits under any other plan? ☐ Yes ☐ No

If yes, name of family member insured: _____ Relationship to employee:_____

Name of other insurance company:_____ Policy Number: _____

Is the treatment required as the result of an accident? ☐ Yes ☐ No

If yes, indicate the accident date, location and details on how the accident occurred. _____

Is the treatment required as the result of a work related injury? ☐ Yes ☐ No

If yes, is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No

4. TO BE COMPLETED BY PROVIDER OF MATERIALS

DATE OF SERVICE:_____(MM/DD/YY)

CHARGES FOR MATERIALS SUPPLIED		
	FRAMES	$_____
	LENS FOR RIGHT EYE	$_____
	LENS FOR LEFT EYE	$_____
	CONTACT LENSES	$_____
	SAFETY GLASSES	$_____
	OTHER *	$_____

TYPE OF LENSES SUPPLIED	LEFT EYE	RIGHT EYE
PLAIN GLASS		
SINGLE VISION		
BIFOCAL		
TRIFOCAL		
CONTACT		

REASON FOR PURCHASE (PLEASE CHECK)

- A. INITIAL PRESCRIPTION _____
- B. PRESCRIPTION CHANGE _____
- C. LOSS OR BREAKAGE _____
- D. PRESCRIPTION SUNGLASSES (PROVIDE TINT AND COLOR NO.) _____
- E. SAFETY GLASSES _____
- F. OTHER (PLEASE EXPLAIN) _____

Was a deposit made? ☐ Yes ☐ No If yes, please indicate the amount of the deposit $_____

* Give reasons and specific item cost for "Other" in area 1 (e.g. hardening, tinting, varigray, oversize lenses, etc.)

If glasses were tinted, what was the tint? _____

Name of Prescribing Optometrist or Ophthalmologist – if signed by Optician

I am a legally qualified ☐ Ophthalmologist ☐ Optometrist ☐ Optician

Signed _____ Date _____

Address: _____ Phone Number: _____

TO ASSIGN PAYMENT TO SUPPLIER:

I hereby assign my benefits payable from this claim to _____ and authorize payment directly to the supplier.

(Name of Supplier)

Member Signature: **Date:**

I hereby authorize any healthcare provider, my plan administrator, my employer, insurance companies, other organizations, or benefit service providers working with Manulife Financial to exchange information when necessary for the purpose of settlement of this claim and to administer the group plan. I authorize release of the information contained in this claim form to the Insurer/Plan Administrator, its authorized representative or consultant for the purpose of settlement of this claim. I understand the information collected is kept in strict confidence and used solely for the purpose of assessing the 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 and that each of the above expenses are for medical treatment that I and/or my dependents received. I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to the supplier for the entire amount.

Do you want any unpaid portion of your claim processed through your Health Spending Account? ☐ Yes ☐ No

SIGNATURE OF MEMBER **DATE** (MM/DD/YY)

Ellement

Phone (780) 452-5161

Please return to:
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