

VISIONCARE CLAIM FORM

SEND THIS CLAIM TO:

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.

All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

Please print

PART 1 EMPLOYEE INFORMATION					
PLAN NUMBER	DIVISION NUMBER	PLAN NAME			
EMPLOYEE IDENTIFICATION NUMBER		EMPLOYEE NAME			DATE OF BIRTH (Year / Month / Day)
ADDRESS: NUMBER AND STREET		TOWN	PROVINCE	POSTAL CODE	PHONE #
		HOME:		WORK:	

PART 2 PATIENT INFORMATION		
PATIENT NAME	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH (Year / Month / Day)
If Dependent, does the patient reside with you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If child 18 years or older: a) Full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many hours per week at school? _____		
b) Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many hours per week? _____		

PART 3 COORDINATION OF BENEFITS	
Are you or any other member of your family entitled to benefits under any other plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, name of family member insured _____ Relationship to employee _____	
Name of other insurance company _____ Policy Number _____	
Is any member of your family (other than yourself) insured as an employee under this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, name of family member _____	
If yes, to either question above, and the patient is a dependent child, please provide spouse's date of birth: _____ / _____ / _____ (Day / Month / Year)	

PART 4 TO BE COMPLETED BY PROVIDER OF MATERIALS			
Date of Service _____	Type of lenses supplied		Reason for purchase (please check)
	Left Eye	Right Eye	
CHARGES FOR	Plain glass	_____	a) Initial prescription _____
Frames \$ _____	Single vision	_____	b) Prescription change _____
Lens for right eye \$ _____	Bifocal	_____	c) Loss or breakage _____
MATERIALS Lens for left eye \$ _____	Trifocal	_____	d) Other (please explain) _____
SUPPLIED Other \$ _____	Contact	_____	
TOTAL \$ _____			
Give reasons and specific item cost for "Other" in area 1 (e.g. hardening, tinting, varigray, oversize lenses, etc.)			
If glasses tinted, what was tint?			
Name of Prescribing Optometrist or Ophthalmologist - if signed by Optician			
I am a legally qualified <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Optometrist <input type="checkbox"/> Optician			
Signed _____		Date _____	
Address _____		Telephone Number _____	

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information when necessary for these purposes. I authorize the use of my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the plan. I certify that the information given is true, correct and complete to the best of my knowledge.

Employee's Signature _____ Date _____