

VISION CARE STATEMENT OF CLAIM

MAIL ALL CLAIM FORMS TO:
 BENEFIT PLAN ADMINISTRATORS LIMITED
 P.O. Box 6020, Station 'B'
 Toronto, Ontario M9W 7A3

BENEFIT PLAN ADMINISTERED BY:
 BENEFIT PLAN ADMINISTRATORS LIMITED

To be completed by Member

Company Name _____		Local No. _____	
Member's Name _____		Identification Number _____	
Member's Address _____		Date of Birth _____ Day Mo. Yr.	
No. and Street _____	City _____	Province _____	Postal Code _____
If Dependent Claim, Name of Dependent _____		Relationship _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F
		Date of Birth _____	Mo. Yr.

DO YOU HAVE ANY OTHER VISION CARE COVERAGE? YES NO IF YES, PLEASE COMPLETE

INSURER'S NAME _____ GROUP NO. _____ POLICY NO. _____ EMPLOYER'S NAME _____

IF CLAIM IS FOR A DEPENDENT CHILD INDICATE SPOUSES DATE OF BIRTH Day _____ Mo. _____ Yr. _____

To be completed by Supplier

Prescribed by Ophthalmologist Optometrist

Prescription Details _____ Patient Name _____ Is this a change in prescription? Yes No

	Sphere	Cylinder	Axis	Prism	Base	Seg Height	Frame and Colour	Eye Size	Manufacturer or Supplier
R									
L									
A									
D	R	Tint (Specify Colour & No.)		Type of Bifocal	Type of Trifocal				
D	L		1		2				

Plastic Heat Hardened Chemically Hardened

For additional information re: complications etc.

Breakdown of extra charges: Transfer items to
 (e.g. over-size, photogrey, case, etc.) misc. below:
 Miscellaneous: Amount:

1. _____ \$ _____
 2. _____ \$ _____
 3. _____ \$ _____
 4. _____ \$ _____

Supplier

Day Month Year

Date of Service

Name _____

Address _____

City/Town _____ Prov. _____ Telephone No. _____

Postal Code Signature _____

Optometrist Optician

PLEASE ATTACH PAID RECEIPT

Frame	Charges
Lenses	
Fee	
Misc. 1.	
Misc. 2.	
Misc. 3.	
Total	

I certify that the above information is true, correct and complete. I authorize Benefit Plan Administrators Limited ("BPA") to collect and use personal information about me and/or my eligible dependents to process this claim and administer my benefit plan. I am aware BPA will keep my personal information confidential and safeguarded. I am aware that BPA will only release personal information to my eligible dependents specific to their benefit entitlements. I understand that my personal information (and the personal information of my eligible dependents) may only be shared with health care practitioners, medical facilities, providers of health care/dental services or benefits administration services, provincial health insurance plans, insurance carriers, government agencies, and auditing or independent investigative organizations in order to verify eligibility for my benefit entitlements.

I understand that my social insurance number will be kept in strictest confidence and will only be used for income tax reporting purposes and to match my information with the correct member file. I consent to the collection, use and disclosure of personal information as stated above.

Member's Signature _____

Date (DD / MM / YY) _____

POSSESSION OF THIS CLAIM FORM DOES NOT CONSTITUTE ELIGIBILITY FOR BENEFITS

SUPPLEMENTARY HEALTH EXPENSE

MAIL ALL CLAIM FORMS TO:
 BENEFIT PLAN ADMINISTRATORS LIMITED
 P.O. Box 6020, Station B
 Toronto, Ontario M9W 7A3

BENEFIT PLAN ADMINISTERED BY:
 BENEFIT PLAN ADMINISTRATORS LIMITED

PLEASE TYPE OR PRINT. INCLUDE ALL INFORMATION INDICATED AND ATTACH ALL RECEIPTS. USE MORE THAN ONE FORM IF NECESSARY.

Company Name		Local No.	
Member's Name	Identification Number	Date of Birth	
Member's Address		Day	Mo. Yr.
No. and Street	City	Province	Postal Code
Have you (or your dependent) any other coverage which would pay a benefit for this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", name of Employer and Insurance Co. _____ Are expenses related to an accident <input type="checkbox"/> Yes <input type="checkbox"/> No W.C.B. case <input type="checkbox"/> Yes <input type="checkbox"/> No		Telephone No. () Are expenses related to an accident <input type="checkbox"/> Yes <input type="checkbox"/> No W.C.B. case <input type="checkbox"/> Yes <input type="checkbox"/> No	
If claim is for a dependent child please indicate spouse's date of birth			
FIRST NAME	SEX	DATE OF BIRTH Day Mo. Yr.	DATE EXPENSE INCURRED
		D M Y	
			DRUGS: NAME OR D.I.N. OTHER: TYPE OF EXPENSE
			AMOUNT CHARGED
M E M B E R			
S P O U S E			
U N M A R R I E D C H I L D			
			Is child employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Hours per week _____

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Date DD MM YY

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