THE
Great-West Life
ASSURANCE COMPANY

VISIONCARE CLAIM FORM

SEND FORM TO:
Winnipeg Benefit Payments
P.O. Box 3050
Winnipeg MB R3C 4E5
1-800-957-9777
(204) 942-3589
TTY line - available for the deaf or hard of hearing
Toll Free: 1-800-990-6654
Phone: (204) 946-7281

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.

NAME OF GROUP **I.B.E.W. L.U. 353 WELFARE PLAN** POLICY NUMBER **51189**

EMPLOYEE NAME ____________________

EMPLOYEE ADDRESS ____________________ ____________ POSTAL CODE

EMPLOYEE ID NUMBER ____________________ DIVISION NUMBER ____________

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 older:
   - 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 birthdate ____ / ____ (DAY / MONTH)
   AND spouse's birthdate ____ / ____ (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) Loss or breakage ____
   - d) Other (please explain) ____ ____________

4. 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?

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

I am a legally qualified ☐ OPHTHALMOLOGIST ☐ OPTOMETRIST ☐ OPTICIAN

SIGNED ____________________ DATE ____________ TELEPHONE # ____________

ADDRESS ____________________

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 ____________

M1214D(51189) BIL-10/04

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