# VISION CARE STATEMENT OF CLAIM

MAIL ALL CLAIM FORMS TO:
BENEFIT PLAN ADMINISTRATORS LIMITED
426 Third Street, 2nd Floor, Suite 200
London, Ontario N5W 4W6

BENEFIT PLAN ADMINISTERED BY:
BENEFIT PLAN ADMINISTRATORS LIMITED

## To be completed by Member

| Company Name | Local No. 552 |
|---|---|

| Member's Name | Identification Number | Date of Birth (Day Mo. Yr.) |
|---|---|---|
| | | |

| Member's Address (No. and Street, City, Province, Postal Code) | Telephone No. ( ) |
|---|---|
| | |

| If Dependent Claim, Name of Dependent | Relationship | Sex ☐M ☐F | Date of Birth (Day 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 SPOUSE'S DATE OF BIRTH Day _____ Mo. _____ Yr. _____

## To be completed by Supplier

Prescribed by ☐ Ophthalmologist ☐ Optometrist

Patient Name _____

Prescription Details

Is this a change in prescription? ☐ Yes ☐ No

| | Sphere | Cylinder | Axis | Prism | Base | Seg Height |
|---|---|---|---|---|---|---|
| R | | | | | | |
| L | | | | | | |

| ADD | Tint (Specify Colour & No.) | Type of Bifocal | Type of Trifocal |
|---|---|---|---|
| R | | | |
| L | 1 2 | | |

Frame and Colour

Eye Size

Manufacturer or Supplier

☐ Plastic ☐ Heat Hardened ☐ Chemically Hardened

For additional information re: complications etc.

_____

_____

**Breakdown of extra charges:** (e.g. oversize, photogrey, case, etc.)

Transfer items to misc. below:

| Miscellaneous: | Amount: |
|---|---|
| 1. _____ | $ _____ \| ___ |
| 2. _____ | $ _____ \| ___ |
| 3. _____ | $ _____ \| ___ |
| 4. _____ | $ _____ \| ___ |
| | _____ \| ___ |

## Supplier

Day ☐☐ Month ☐☐ Year ☐☐

Date of Service

_____

Name

_____

Address

_____ ( ) _____

City/Town Prov. Telephone No.

Postal Code ☐☐☐ ☐☐☐

☐ Optometrist ☐ Optician Signature _____

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

## PLEASE ATTACH PAID RECEIPT

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***