

I.U.P.A.T. DISTRICT COUNCIL 38 HEALTH & WELFARE

Vision Care Claim Form

(USE A SEPARATE CLAIM FORM FOR EACH PERSON CLAIMING)

August 1, 2006

Member's Name: _____ Social Insurance No: _____

Address: _____

City: _____ Postal Code: _____ Phone No: (____) _____

Name of DEPENDENT Claiming: _____ DEPENDENT Birth Date: _____ DEPENDENT Number: _____
Month/Day/Year

Eyeglasses: Date Purchased: _____ Receipt #: _____ Cost: \$ _____

Contacts: Date Purchased: _____ Receipt #: _____ Cost: \$ _____

Total Claimed: \$ _____

Check if you or your dependents have **other insurance** to cover these expenses. If yes, please provide the name of the insurance company and the identification number.

I Hereby certify that the above listed expenses were incurred by me or my dependents on the date(s) shown and that the information and amounts are correct.

COMPANY NAME

MEMBER'S SIGNATURE

IDENTIFICATION NUMBER

DATE SIGNED

*****THIS SECTION FOR OFFICE USE ONLY*****

Amount Eligible for Reimbursement (Maximum \$475.00 Members/\$300.00 Dependents) \$ _____

Less Amount(s) Paid in Previous 24 Month Period: Date: _____ \$ _____

Date: _____ \$ _____

Amount Eligible for Reimbursement: \$ _____

Paid This Claim: Date: _____ Chq#: _____ \$ _____

Unused Benefit: \$ _____

Next Eligible Date(s)

\$ _____ After: _____

\$ _____ After: _____

GENERAL INFORMATION – VISION CARE

August 1, 2006

❖ **USE A SEPARATE FORM FOR EACH PERSON CLAIMING, DO NOT PUT MORE THAN ONE CLAIM ON EACH FORM**

❖ **BENEFIT LEVEL**

(Effective August 1, 2006) Up to \$475.00 will be paid towards the purchase of prescription eyewear for each covered *member* (total can include **Eye Exam for MEMBER only**), and up to \$300.00 for their registered eligible dependents in each 24 month period.

Please call (604) 524-8334 or toll free 1-800 266-1527 if you have any questions regarding coverage and/or eligibility.

❖ **MAIL COMPLETED FORMS TO:**

**IUPAT District Council 38 Health & Welfare
7621 Kingsway
Burnaby, B.C. V3N 3C7**

❖ **ALL CLAIMS MUST BE SUPPORTED BY ITEMIZED ORIGINAL PAID RECEIPTS WHICH INDICATE:**

- (a) Patients Name
- (b) Type of Purchase
- (c) Date of Purchase
- (d) Amount Paid

❖ **DEADLINE:** All claims for eligible Vision Care expenses incurred in a given year **MUST** be submitted to the Union Health & Welfare Office prior to June 30th of the following year.

If you have additional coverage through your spouse's plan:

If you purchase glasses or contact lenses for yourself, submit the receipt to your plan first. Once your claim is processed, a copy of your claim plus a copy of your receipt will be mailed back to you with a cheque (up to \$475.00 maximum). If the total cost of your glasses or contacts exceeds \$475.00 *you may be able to resubmit* your receipt to your spouse's plan to make up part of the difference.

If your spouse purchases glasses or contacts, *he or she must claim on his or her own plan first.* If their plan does not pay 100% of the total amount of the bill, submit a copy of the receipt PLUS a copy of the statement of payment from your spouse's plan, and DC38's plan will consider the balance up to a maximum of \$300.00.

The total reimbursement through both plans will not be more than 100% of the original cost of the glasses or contacts.

August 1/06