

Vision Care Claim Form

(USE A SEPARATE CLAIM FORM FOR EACH PERSON CLAIMING)

Member Name: _____ Social Insurance No.: _____ / /

Address: _____

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

Name of Dependent Claiming _____	Dependent Birth Date _____ Month / Day / Year	Dependent Number _____
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Eye Exam: Date Purchased: _____ Receipt #: _____ Cost: \$ _____

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 company and the identification number:

I hereby certify that the above listed expenses are 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 \$ _____

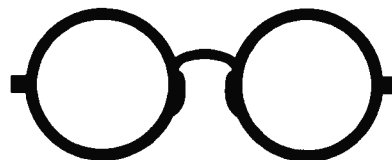
Paid this Claim: Date: _____ Chq #: _____ \$ _____

Unused Benefit \$ _____

Next Eligible Date(s)

\$ _____ after _____

\$ _____ after _____



GENERAL INFORMATION

- ❖ **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 reimbursed towards the purchase of corrective lenses and frames or contact lenses for each covered *member* (total can include **Eye Exam for member only**), and up to \$300.00 for each of 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.