VISION CARE STATEMENT OF CLAIM

MAIL ALL CLAIM FORMS TO:
BENEFIT PLAN ADMINISTRATORS LIMITED

BENEFIT PLAN ADMINISTERED BY:
BENEFIT PLAN ADMINISTRATORS LIMITED

To be completed by Member

Company Name		Local No.
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

Prescription Details

Patient Name _____

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