

SEND FORM TO:
 Great-West Life Health & Dental Benefits
 P.O. Box 3050
 Winnipeg MB R3C 4E5
 1-800-957-9777
 (204) 942-3589



VISIONCARE
 CLAIM FORM

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

NAME OF GROUP THE CORPORATION OF THE CITY OF BRAMPTON POLICY NUMBER 51257
 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 _____	2. Type of lenses supplied Left Eye Right Eye	3. Reason for purchase (please check)
Frames \$ _____	Plain glass _____	a) Initial prescription _____
CHARGES FOR Lens for right eye \$ _____	Single vision _____	b) Prescription change _____
SUPPLIED: Lens for left eye \$ _____	Bifocal _____	c) Loss or breakage _____
Other \$ _____	Trifocal _____	d) Other (please explain) _____
TOTAL \$ _____	Contact _____	

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 _____

Personal information we collect from you is kept in strict confidence and will be used to assess your claim and to administer the group benefit plan. I authorize the use of my Social Insurance Number as an identification number where it is required in the administration of my group benefit plan. I authorize Great-West, any healthcare provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with Great-West to exchange information when necessary to assess my claim and to administer the group benefit plan. I certify that the information given is true, correct and complete to the best of my knowledge.

EMPLOYEE'S SIGNATURE _____ DATE _____