

VISIONCARE CLAIM FORM

SEND THIS CLAIM TO:

Questions? Call Toll Free: 1.800.957.9777

Winnipeg Benefit Payments
PO Box 3050 Station Main
Winnipeg MB R3C 0E6



For the deaf or hard of hearing:
Toll Free: 1.800.990.6654

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.

All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

Please print

PART 1 EMPLOYEE INFORMATION						
PLAN NUMBER	DIVISION NUMBER	PLAN NAME				
EMPLOYEE IDENTIFICATION NUMBER		EMPLOYEE NAME			DATE OF BIRTH (Year / Month / Day)	
ADDRESS: NUMBER AND STREET		TOWN	PROVINCE	POSTAL CODE	PHONE #	
				HOME:	WORK:	

PART 2 PATIENT INFORMATION		
PATIENT NAME	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH (Year / Month / Day)
If Dependent, does the patient reside with you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If child 18 years or older: a) Full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many hours per week at school? _____		
b) Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many hours per week? _____		

PART 3 COORDINATION OF BENEFITS	
Are you or any other member of your family entitled to benefits under any other plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, name of family member insured _____ Relationship to employee _____	
Name of other insurance company _____ Policy Number _____	
Is any member of your family (other than yourself) insured as an employee under this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, name of family member _____	
If yes, to either question above, and the patient is a dependent child, please provide spouse's date of birth: _____ / _____ / _____ (Day / Month / Year)	

PART 4 TO BE COMPLETED BY PROVIDER OF MATERIALS			
Date of Service _____	Type of lenses supplied		Reason for purchase (please check)
	Left Eye	Right Eye	
CHARGES FOR	Frames \$ _____	Plain glass _____	a) Initial prescription _____
MATERIALS	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 _____	

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?

Name of Prescribing Optometrist or Ophthalmologist - if signed by Optician

I am a legally qualified Ophthalmologist Optometrist Optician

Signed _____ Date _____

Address _____ Telephone Number _____

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life, located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge.

Employee's Signature _____ Date _____