



VISION CLAIM FORM

INSTRUCTIONS

- 1. Employee/member fully complete Part 1.
2. Ophthalmologist, Optometrist or Optician to complete Part 2.
3. For eye exams, please complete an "Extended Health Care Claim Form".

ASSIGNMENT OF BENEFIT

I hereby assign my benefits payable from this claim to the named supplier and authorize payment directly to said supplier.

X \_\_\_\_\_
Employee's/Member's Signature

PART 1 EMPLOYEE/MEMBER STATEMENT (Please Print)

Form with fields for Group Policy No., Account No., PID #, Name of Employer/Policyholder, Employee/Member: Last Name, First Name, Date of Birth (D/M/Y), Mailing Address: Number - Street, New Address, Apt. No., City, Province, Postal Code, Patient Name, Relationship, Date of Birth (D/M/Y), Student, Handicapped.

- 1. Are benefits payable from any other company/source?
2. Is this your first benefit claim with The Co-operators?
3. If your Plan provides a Health Spending Account, should any unpaid balance of this claim be reimbursed under your account?
4. If patient is a student over the age 18, name of school, Student status, Enrolled in the semester starting, Will student be graduating at the end of the semester indicated?

Co-operators Life Insurance Company Privacy Statement

Co-operators Life Insurance Company ("Co-operators") is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

I certify that the information contained herein is true, complete and accurate and that each of the listed expenses was purchased and/or incurred in connection with medical treatment of the above-named individuals. I acknowledge that the submission of false or incomplete information may result in the delay or denial of this claim.

X \_\_\_\_\_
Employee's/Member's Signature

X \_\_\_\_\_
Date

PART 2 SUPPLIER STATEMENT — THIS SECTION MUST BE COMPLETED IN FULL

Form with fields for OPTICAL SUPPLIES, Date, Nature of Visual Defect, Is this first pair of glasses or contact lenses?, If "No" did prescription change from previous one?, CHARGES FOR MATERIALS SUPPLIED, Name of prescribing Ophthalmologist or Optometrist, Name and Address of Supplier, Signature, Date, Telephone Number.

PART 3 EMPLOYER/POLICYHOLDER (Only If Authorization Required)

Form with fields for Employee's/Member's Effective Date (D/M/Y), Dependant's Effective Date (D/M/Y), Termination Date (D/M/Y) (If applicable), Signature of Employer/Plan Administrator Official, Classification, Date.