THE Great-West Life ASSURANCE COMPANY

VISIONCARE CLAIM FORM

SEND FORM TO:
Regina Benefit Payments
P.O. Box 4408
Regina SK S4P 3W7
English: 1-866-289-5675
French: 1-866-814-6503
TTY line - available for the deaf or hard of hearing
Toll Free: 1-800-990-6654
Phone: (204) 946-7281

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.

NAME OF GROUP _____ POLICY NUMBER 56127

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 _____

CHARGES FOR MATERIALS SUPPLIED:

Frames	$_____
Lens for right eye	$_____
Lens for left eye	$_____
Other	$_____
TOTAL	$_____

2. Type of lenses supplied

	Left Eye	Right Eye
Plain glass		
Single vision		
Bifocal		
Trifocal		
Contact		

3. Reason for purchase (please check)
   - a) Initial prescription _____
   - b) Prescription change _____
   - c) Loss or breakage _____
   - d) Other (please explain) _____

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 _____

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. 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 to exchange personal information when necessary for these purposes. I authorize the use of my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the plan. I certify that the information given is true, correct and complete to the best of my knowledge.

EMPLOYEE'S SIGNATURE _____ DATE _____