

How to complete your Visioncare Claim Form

SEND FORM TO: **THE Great-West Life ASSURANCE COMPANY** **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 _____ POLICY NUMBER _____
 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 MATERIALS SUPPLIED: Lens for right eye \$ _____	Single vision _____	b) Prescription change _____
Lens for left eye \$ _____	Bifocal _____	c) Loss or breakage _____
Other \$ _____	Trifocal _____	d) Other (please explain) _____
TOTAL \$ 0.00	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 _____

Complete these sections in full.

Have your Ophthalmologist, Optometrist or Optician complete these sections in full.

Mail your completed form to the office listed in your plan booklet, or as indicated by your plan administrator.

Attach all original receipts to your claim form.

Authorization
 The Employee must sign and date here upon completion of this form.

Incomplete forms may be returned to you and delay processing.

Consult your plan administrator if you have any questions.