Chambers of Commerce
Group Insurance Plan®

Please print your Firm & Certificate #

Firm # | Certificate #

V I S I O N C A R E C L A I M

Please print clearly. Use this form to claim Vision Care benefits only. Your plan covers corrective eyeglasses, contact lenses, and laser eye surgery, up to the maximum amount payable and frequency restrictions in your firm's plan. **All the information you provide on this form will be treated as confidential.**

- The employee completes Sections A and B. Please provide all the information requested.
- Sections C and D are optional, completed only when the employee wants the plan benefits paid directly to the service provider.
- **Send us an original, itemized receipt, unless the employee completes Section C.** For assigned benefits, all we need is the completed claim form.
- Send the claim to the Plan Administrator at: **Chambers of Commerce Group Insurance Plan, 582 King Edward Street, Winnipeg, Manitoba R3H 0P1**
- Insuring Company: Desjardins Financial Security

A. EMPLOYEE DATA

Employee's Last Name _____ Employee's Given Name(s) _____

Employee's Full Mailing Address _____

Patient's Last Name (if other than the employee) _____ **Patient's Given Name(s)** _____

Patient's Date of Birth (M/D/Y) _____

Are you claiming for a dependent child who is age 21 or older? ❑ Yes ❑ No If "Yes," child's name _____

Child is ❑ physically/mentally handicapped ❑ a student enrolled **full time** at (school's name) _____

B. EMPLOYEE'S DECLARATION

1. The vision correction was prescribed by the patient's
   ❑ Opthamologist ❑ Optometrist ❑ Physician
2. This purchase was made on (M/D/Y) _____
3. The total amount of the purchase was $ _____
4. Are you eligible for any other vision care insurance benefits or services?
   ❑ Yes ❑ No
5. If you answered YES to question 4, please provide the following.
   Family Member Insured _____
   Policy No. _____
   Name and address of insuring company _____

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 certify that the answers to the above questions are full and true to the best of my knowledge and that the enclosed receipts represent a claim for services rendered to me and/or eligible members of my family. If this claim is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them, for the purposes of assessing and paying a benefit, if any. I authorize the Chambers Plan, its agents and service providers, any health care provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with the Chambers Plan and its insurance companies to exchange information when necessary to assess my claim and to administer the group benefit plan. A photocopy of this authorization is as valid as the original.

Employee's Signature _____ Date _____

C. ASSIGNMENT OF BENEFITS

*Complete this section **only** if you want the benefits payable sent directly to your service provider.* **(Supplier must complete Section D.)**

I hereby assign benefits to the following supplier. I understand that the charges listed on this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to the above supplier for the costs I have incurred here.

Supplier's Name _____

Employee's Signature _____ Full Mailing Address _____

D. SUPPLIER'S REPORT

1. Date of Service (M/D/Y) _____
2. Charges
   Frames $ _____
   Right Lens $ _____
   Left Lens $ _____
   Other $ _____
   TOTAL $ _____
3. Types of lenses

	Left Eye	Right Eye
Plain glass		
Single vision		
Bifocal		
Trifocal		
Contact		

4. Describe any "Other" charges, including itemized costs. _____
5. If you provided tinted lenses, what kind of tint was used? _____
6. What is the nature of the patient's visual impairment? _____
7. Prescribing Optometrist's or Opthamologist's name. _____
8. I certify that I am a legally qualified ❑ Opthamologist ❑ Optometrist ❑ Optician and that the services listed above are correct and represent those provided to the named patient.

Signed _____ Date _____ Telephone _____

Address _____

THIS PLAN DOES NOT COVER ANY CHARGES FOR THE COMPLETION OF A FORM.