IUPAT LOCAL 177 WELFARE TRUST FUND

VISION CLAIM FORM

INSTRUCTIONS: Use a separate form for each family member. Attach the original receipts for all expenses. Receipts will not be returned, as a copy of the Explanation of Benefits is sent to you and copies of receipts are sufficient for income tax purposes or coordination of benefits with other group plans.
Your claim will be returned to you if the claim form is incomplete.

1. MEMBER INFORMATION

GROUP NUMBER
5801

LAST NAME	FIRST NAME	CERTIFICATE/SIN NUMBER

ADDRESS	GENDER	LANGUAGE	DATE OF BIRTH (MM/DD/YY)
	☐ Male ☐ Female	☐ English ☐ French	

CITY	PROVINCE	POSTAL CODE	PHONE NUMBER

2. PATIENT INFORMATION

PATIENT NAME	RELATIONSHIP TO MEMBER	PATIENT DATE OF BIRTH (MM/DD/YY)

If Dependent, does the patient reside with you? Yes ☐ No ☐

If child 18 years of age or older a) Full-time student? ☐ If yes, how many hours per week at school? _____ Yes ☐ No ☐

b) Employed? ☐ If yes, how many hours per week? ____ Yes ☐ No ☐

3. COORDINATION OF BENEFITS

Are you or any other member of your family entitled to benefits under any other plan? Yes ☐ No ☐

If yes, name of family member insured: _____ Relationship to employee:_____

Name of other insurance company:_____ Policy Number: _____

Is the treatment required as the result of an accident? Yes ☐ No ☐

If yes, indicate the accident date, location and details on how the accident occurred. _____

Is the treatment required as the result of a work related injury? Yes ☐ No ☐

If yes, is a claim being made for Worker's Compensation Benefits? Yes ☐ No ☐

4. TO BE COMPLETED BY PROVIDER OF MATERIALS

DATE OF SERVICE:_____(MM/DD/YY)

CHARGES FOR MATERIALS SUPPLIED

FRAMES	$ _____
LENS FOR RIGHT EYE	$ _____
LENS FOR LEFT EYE	$ _____
CONTACT LENSES	$ _____
SAFETY GLASSES	$ _____
OTHER *	$ _____

TYPE OF LENSES SUPPLIED

	LEFT EYE	RIGHT EYE
PLAIN GLASS		
SINGLE VISION		
BIFOCAL		
TRIFOCAL		
CONTACT		

REASON FOR PURCHASE (PLEASE CHECK)

A. INITIAL PRESCRIPTION	
B. PRESCRIPTION CHANGE	
C. LOSS OR BREAKAGE	
D. PRESCRIPTION SUNGLASSES (PROVIDE TINT AND COLOR NO.)	
E. SAFETY GLASSES	
F. OTHER (PLEASE EXPLAIN)	

Was a deposit made? Yes ☐ No ☐ If yes, please indicate the amount of the deposit $_____

* 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: _____ Phone Number:_____

TO ASSIGN PAYMENT TO SUPPLIER:

I hereby assign my benefits payable from this claim to _____ and authorize payment directly to the supplier.
(Name of Supplier)

Member Signature: **Date:**

I hereby authorize any healthcare provider, my plan administrator, my employer, insurance companies, other organizations, or benefit service providers working with Funds Administrative Service Inc. to exchange information when necessary for the purpose of settlement of this claim and to administer the group plan. I authorize release of the information contained in this claim form to the Insurer/Plan Administrator, its authorized representative or consultant for the purpose of settlement of this claim. I understand the information collected is kept in strict confidence and used solely for the purpose of assessing the 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 and that each of the above expenses are for medical treatment that I and/or my dependents received. I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to the supplier for the entire amount.

SIGNATURE OF MEMBER DATE (MM/DD/YY)

FAS
Phone (780) 452-5161

Please return to:
Funds Administrative Service Inc.
10154 – 108 Street, NW, Edmonton, AB T5J 1L3
Toll free: 1-800-770-2998

Fax (780) 452-5388