

**Bricklayers & Allied Craftworkers Insurance Benefit Trust Fund of Alberta and Saskatchewan
VISION CARE – STATEMENT OF CLAIM**

Policy #XS-6128-0

PLEASE NOTE: To be completed by member – please use a separate form for each family member.
Your Claim Cannot Be Processed Unless All Questions Have Been Answered in Full.

Member Information		Local Union No					
Name (Last)	(First)	Sex (circle)		Date of Birth			
		M	F	M	D	Y	
Address (Street)		Social Insurance Number					
(City)	Prov	Postal Code			Telephone Number		

If Dependent Claim, Name of Dependent	Relationship	Sex (circle)		Date of Birth			
		M	F	M	D	Y	

Have you (or your dependent) any other coverage which would pay a benefit for this claim?
 Yes No Health only Dental only Both

If "YES" and claim is for dependent child, please indicate spouse's date of birth: Month Day Year	If coordination of benefits no longer applies, please indicate termination date:
If "YES" please attach photocopies of vision receipts and the co-insurance statement.	Month Day Year

If child, indicate <input type="checkbox"/> Handicapped <input type="checkbox"/> Full-Time Student Attending School at:	Date Enrolled			Date Completed		
	M	D	Y	M	D	Y

1. Were frames obtained?	<input type="checkbox"/> Yes <input type="checkbox"/> No	SUPPLIER Name Address City/Town Prov Postal Code Telephone Number ()
2. Were lenses <input type="checkbox"/> Single Vision <input type="checkbox"/> Bi-focal	<input type="checkbox"/> Tri-focal	
3. Were contact lenses obtained?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Were sunglasses obtained?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Were these initial glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Was there a change in prescription?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

7. Any other reason for obtaining glasses?

OPTOMETRISTS If tint has been added to the lenses prescribed, please confirm the type of tint added.	TO ASSIGN PAYEMENT TO SUPPLIER: I hereby assign my benefits payable from this claim to the supplier named above and authorize payment directly to the supplier. (Please attach an invoice confirming the dates of service.) Signature
--	--

I hereby authorize any healthcare provider, my plan administrator, my employer, insurance companies, other organizations, or benefit service providers working with Manulife Financial to exchange information when necessary for the purpose of settlement of this claim and to administer the group plan. I authorize the 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	Date
-----------	------

PLEASE ATTACH ORIGINAL PAID IN FULL RECEIPT IF YOU ARE CLAIMING REIMBURSEMENT

Please return to:	Funds Administrative Service Inc. 9 th floor, 9707-110 Street Edmonton, AB T5K 3T4	Toll Free 1-800-770-2998
Phone (780) 452-5161		