THE Great-West Life ASSURANCE COMPANY

VISION CARE STATEMENT OF CLAIM
CANADIAN CONSTRUCTION WORKERS' UNION BENEFIT TRUST FUND

MAIL ALL CLAIMS TO: **CANADIAN CONSTRUCTION WORKERS' UNION BENEFIT TRUST FUND**
1263 WILSON AVENUE SUITE 205
NORTH YORK ONTARIO M3M 3G2

CLAIM ENQUIRIES: **416.240.0047**

PLEASE ATTACH THE PAID RECEIPT

To be completed by member

Employer	Employer location (city and prov.)		
Member's Name	Policy No.	Identification No.	Date of Birth Mo. Day Yr.
Member's Address No. and Street City Prov. Postal Code			Telephone No.
If Dependant Claim, Name of Dependant	Relationship	Sex ☐ M ☐ F	Date of Birth Mo. Day Yr.

DO YOU HAVE ANY OTHER VISION CARE COVERAGE? ☐ YES ☐ NO ☐ IF YES, PLEASE COMPLETE:

INSURER'S NAME _____ GROUP NO. _____ POLICY NO. _____ EMPLOYER'S NAME _____

IF YES, AND CLAIM IS FOR A DEPENDENT CHILD, PLEASE INDICATE SPOUSE'S DATE OF BIRTH _____

☐ Initial Claim
☐ Subsequent Claim

Date Signature of Member

TO BE COMPLETED BY SUPPLIER

Prescribed by ☐ Ophthamologist ☐ Optometrist **Is this a change in prescription?** ☐ Yes ☐ No

Prescription Details

		Sphere	Cylinder	Axis	Prism	Base	P.D.	Seg Height	Frame and Colour		
R							FAR		Eye Size	DBL	Temple
L							NEAR				
ADD			Tint (Specify Colour & No.)		Type of Bifocal		Type of Trifocal		Manufacturer of Supplier		
	R										
	L		1 2								

☐ Plastic ☐ Heat Hardened ☐ Chemically Hardened

For additional information re complications ect.

Breakdown of extra charges: (e.g. oversize, photogrey, case, ect.)
Miscellaneous:
1. _____ $ _____
2. _____ $ _____
3. _____ $ _____
4. _____ $ _____
Total _____

Transfer items to misc. below Amount:

Supplier Day Month Year
Date of service

Name

Address

City/Town Prov. Telephone No.

Postal Code

☐ Optometrist ☐ Optician

Charges
Frames
Lenses
Fee
Misc. 1.
Misc. 2.
Misc. 3.
Total

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. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

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, located within or outside Canada, 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 understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge.

Plan Member's Signature _____ Date _____

YOUR CLAIM CANNOT BE PROCESSED UNLESS ALL QUESTIONS ARE ANSWERED IN FULL

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Clear