THE Great-West Life ASSURANCE COMPANY

VISIONCARE CLAIM FORM

SEND THIS CLAIM TO:

Questions? Call Toll Free: 1.800.957.9777

For the deaf or hard of hearing:
Toll Free: 1.800.990.6654

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.**

All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

Please print

PART 1 EMPLOYEE INFORMATION

PLAN NUMBER	DIVISION NUMBER	PLAN NAME
EMPLOYEE IDENTIFICATION NUMBER	EMPLOYEE NAME	DATE OF BIRTH (Year / Month / Day)
ADDRESS: NUMBER AND STREET / TOWN / PROVINCE / POSTAL CODE		PHONE # HOME: WORK:

PART 2 PATIENT INFORMATION

PATIENT NAME	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH (Year / Month / Day)

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

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

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

PART 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 any member of your family (other than yourself) insured as an employee under this plan? ☐ Yes ☐ No

If yes, name of family member _____

If yes, to either question above, and the patient is a dependent child, please provide spouse's date of birth: _____ / _____ / _____ (Day / Month / Year)

PART 4 TO BE COMPLETED BY PROVIDER OF MATERIALS

Date of Service _____

CHARGES FOR MATERIALS SUPPLIED	Frames	$_____
	Lens for right eye	$_____
	Lens for left eye	$_____
	Other	$_____
	TOTAL	$_____

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) Other (please explain) _____

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 _____ Telephone Number _____

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 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.

Employee's Signature _____ Date _____

CLEAR