VISION FORM

Plan Member's Full Name:	Group or Employer	Group # 513982	Certificate # (Student #) L
	St. Clair College	Date of Birth Day / Month / Year	

Plan Member's Address

Street _____

Apt. _____ City _____

Province _____ Postal Code _____

Phone No _____

Language Preference ❑ English ❑ French

Identification of the Vision Provider

Name _____

Street _____

Suite. _____ City _____

Province _____ Postal Code _____

COMPLETE THIS SECTION IF CLAIMING FOR YOUR DEPENDENTS

Dependent's name (Last, First)	Date of Birth Day	Month	Year	Relationship to Plan Member
				Spouse ☐ Daughter ☐ Son ☐ Other (describe) _____

DETAILS OF THE PRESCRIPTION

		Sphere	Cylinder	Axis	Prism	Add
New Rx	Right					
	Left					
Old Rx	Right					
	Left					

❑ initial prescription ❑ prescription sunglasses ❑ Rx duplicate
❑ new prescription ❑ contact lenses ❑ replacement
❑ safety glasses ❑ lenses only ❑ frames only
❑ post cataract
❑ other: (indicate any medical conditions or disease

_____

If claim is for contact lenses:
Can visual acuity be restored to ❑ 20/70? ❑ 20/40?
Are the contact lenses medically necessary due to keratocunus, irregular astigmatism, aphakias, or irregular corneal curvature? ❑ Yes ❑ No
Can visual acuity be improved by at least two lines on the Snelian chart over the best possible vision with glasses? ❑ Yes ❑ No

VISION EXPENSES (Attach original paid in full receipts and list below)

Nature of expense	Date incurred Day/Month/Year	Amount

1. Are any health benefits or services provided under any other group insurance or health plan, Worker's Compensation or government plan? ☐ Yes ☐ No

2. Name of other insuring agency or plan _____

Total Claim $

3. Indicate member under other plan: ☐ Self ☐ Spouse

Name _____ Date of Birth Day Month Year

Group No. _____ Certificate No. _____

N.B. **For coordination of benefits**, children must claim under the plan of the parent with the earlier month and day of birth in the calendar year.

I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purposes of assessing and paying a benefit if any. I acknowledge that unless assigned to the service provider, any reimbursement of the above charges and explanation of such amounts paid will be provided to the benefit plan member. I authorize ClaimSecure, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure to exchange necessary information regarding this claim to administer my health benefit plan.

Plan Member's Signature_____ Date_____

Send all claims and inquiries to:
CLAIMSECURE INC.
PO BOX 6500 STN A SUDBURY ON P3A 5N5 1-888-513-4464