

## VISION FORM

|                          |                                                    |                                                                                             |
|--------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------|
| Plan Member's Full Name: | Group or Employer<br><br><b>Seneca Polytechnic</b> | Group # <b>100003</b> Certificate # <b>N</b><br><hr/> Date of Birth      Day / Month / Year |
|--------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------|

| Plan Member's Address                                                                                                                                                               | Identification of the Vision Provider                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| Street _____<br>Apt. _____ City _____<br>Province _____ Postal Code _____<br>Phone No _____<br>Language Preference <input type="checkbox"/> English <input type="checkbox"/> French | Name _____<br>Street _____<br>Suite. _____ City _____<br>Province _____ Postal Code _____ |

### COMPLETE THIS SECTION IF CLAIMING FOR YOUR DEPENDENTS

| Dependent's name<br>(Last, First) | Date of Birth            | Relationship to Plan Member                                                                                              |
|-----------------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------|
|                                   | Day      Month      Year |                                                                                                                          |
|                                   |                          | Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/><br>Other (describe) _____ |

### DETAILS OF THE PRESCRIPTION

|               | Sphere | Cylinder | Axis | Prism | Add |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|---------------|--------|----------|------|-------|-----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>New Rx</b> | Right  |          |      |       |     | <input type="checkbox"/> initial prescription <input type="checkbox"/> prescription sunglasses <input type="checkbox"/> Rx duplicate<br><input type="checkbox"/> new prescription <input type="checkbox"/> contact lenses <input type="checkbox"/> replacement<br><input type="checkbox"/> safety glasses <input type="checkbox"/> lenses only <input type="checkbox"/> frames only                                                                                                                              |
|               | Left   |          |      |       |     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Old Rx</b> | Right  |          |      |       |     | <input type="checkbox"/> post cataract<br><input type="checkbox"/> other: (indicate any medical conditions or disease) _____                                                                                                                                                                                                                                                                                                                                                                                     |
|               | Left   |          |      |       |     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|               |        |          |      |       |     | If claim is for contact lenses:<br>Can visual acuity be restored to <input type="checkbox"/> 20/70? <input type="checkbox"/> 20/40?<br>Are the contact lenses medically necessary due to keratoconus, irregular astigmatism, aphakias, or irregular corneal curvature? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Can visual acuity be improved by at least two lines on the Snellen chart over the best possible vision with glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

| Nature of expense | Date incurred<br>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?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 2. Name of other insuring agency or plan<br>_____ | <b>Total Claim \$</b> |  |  |  |  |  |     |       |      |  |  |
| 3. Indicate member under other plan:<br><input type="checkbox"/> Self <input type="checkbox"/> Spouse                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                   |                       |  |  |  |  |  |     |       |      |  |  |
| Name _____ Date of Birth <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">Day</td> <td style="text-align: center;">Month</td> <td style="text-align: center;">Year</td> <td colspan="2"></td> </tr> </table> Group No. _____ Certificate No. _____ |                                                   |                       |  |  |  |  |  | Day | Month | Year |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                   |                       |  |  |  |  |  |     |       |      |  |  |
| Day                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Month                                             | 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**