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

Policy #6128

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) M F	Date of Birth M D Y
Address (Street)		Social Insurance Number	
(City)	Prov	Postal Code	Telephone Number

If Dependent Claim, Name of Dependent	Relationship	Sex (circle) M F	Date of Birth 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 "YES" please attach photocopies of vision receipts and the co-insurance statement.

If coordination of benefits no longer applies, please indicate termination date:
Month Day Year

If child, indicate
☐ Handicapped
☐ Full-Time Student Attending School at:

Date Enrolled M D Y

Date Completed M D Y

1. Were frames obtained?		☐ Yes	☐ No
2. Were lenses	☐ Single Vision ☐ Bi-focal	☐ Tri-focal	
3. Were contact lenses obtained?		☐ Yes	☐ No
4. Were sunglasses obtained?		☐ Yes	☐ No
5. Were these initial glasses?		☐ Yes	☐ No
6. Was there a change in prescription?		☐ Yes	☐ No

7. Any other reason for obtaining glasses?
8. Is Claim for Eye Exam?
9. Do you want any unpaid portion of your claim processed through your Health Spending Account? ☐ Yes ☐ No

SUPPLIER
Name
Address
City/Town Prov Postal Code
Telephone Number
( )

TO ASSIGN PAYMENT 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 REIMBURSMENT

Please return to:
Funds Administrative Service Inc.
9th floor, 9707-110 Street
Edmonton, AB T5K 3T4

Phone (780) 452-5161 Toll Free 1-800-770-2998