

**INSTRUCTIONS**

1. Attach original receipts being claimed.
2. Employee/member fully complete Part 1.
3. Ophthalmologist, Optometrist or Optician to complete Part 2.
4. For eye exams, please complete an "Extended Health Care Claim Form".  
If provider of the service is to be reimbursed, please complete the "Assignment of Benefits" section.

**ASSIGNMENT OF BENEFIT**

I hereby assign my benefits payable from this claim to the named supplier and authorize payment directly to said supplier.  
 X \_\_\_\_\_  
 Employee's/Member's Signature

**PART 1 EMPLOYEE/MEMBER STATEMENT (Please Print)**

Group Policy No.	Account No.	Certificate/id #	Name of Policyholder
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1. Employee's/Member's name: \_\_\_\_\_ Previous name (if applicable): \_\_\_\_\_  
(first) (initial) (last)

2. Employee's/Member's mailing address: \_\_\_\_\_  
(Street) (City) (Prov) (PostalCode)  
 Check here if this is a change of address.  
D M Y

3. Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

4. Have you (your dependent) any other coverage which would pay a benefit for this claim?  Yes  No  
D M Y  
 If "YES", name company or source: \_\_\_\_\_ Spouse's date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
D M Y  
 If coordination of benefits no longer applies, indicate termination date \_\_\_\_/\_\_\_\_/\_\_\_\_

5. If your Plan provides a Health Spending Account, should any unpaid balance of this claim be reimbursed under your account?  Yes  No

6. Patient name: \_\_\_\_\_ Relationship  Spouse  Son  Daughter  other \_\_\_\_\_

7. Is patient:  student  handicapped  
 If patient is a student over the age 18, name of school: \_\_\_\_\_  
 Student status:  Full-time  Part-time  Correspondence. Enrolled in the semester starting \_\_\_\_\_ (date) and ending \_\_\_\_\_ (date).  
 Will student be graduating at the end of the semester indicated?  Yes  No

**Retain photocopies of your receipts for your records**

**Co-operators Life Insurance Company Privacy Statement**

Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business..

I certify that the information contained herein is true, complete and accurate and that each of the listed expenses was purchased and/or incurred in connection with medical treatment of the above-named individuals. I acknowledge that the submission of false or incomplete information may result in the delay or denial of this claim. I authorize any physician, dentist or any health care provider and/or facility, any insurance company, benefit service provider and any other person or organization having any medical or other relevant personal information regarding me or my spouse and/or dependant to release to and exchange with Co-operators, the group plan administrator or their representatives and/or agents any and all information necessary to investigate and confirm the accuracy and validity of this claim, determine eligibility for benefits and/or administer the claim and group benefit plan. I confirm that I am authorized to act on behalf of my spouse and/or dependants for such purposes. Any copy of this authorization shall be as valid as the original.

X \_\_\_\_\_  
 Employee's/Member's Signature

X \_\_\_\_\_  
 Date (D/M/Y)

**PART 2 SUPPLIER STATEMENT — THIS SECTION MUST BE COMPLETED IN FULL**

Optical Supplies Furnished to _____	Date (D/M/Y) Dispensed _____	Nature of Visual Defect _____
<b>Is this first pair of glasses or contact lenses?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If "No" did prescription change from previous one?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Please check items supplied <input type="checkbox"/> Frames <input type="checkbox"/> Glass/Plastic Lenses <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Prescription or non prescription sunglasses. If contact lenses were supplied, please complete the following: Were lenses prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus, or aphakia? <input type="checkbox"/> Yes <input type="checkbox"/> No Can visual acuity be improved to at least the 20/40 level by contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No Could visual acuity be improved to at least the 20/40 level by spectacle lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>CHARGES FOR MATERIALS SUPPLIED:</b> Frames \$ _____ Lens for Right Eye _____ Lens for Left Eye _____ Hardex or Safety Lens _____ Photo Gray or Tinting _____ Dispensing Fee _____ Other (Specify) _____ Total \$ _____	Name of prescribing Ophthalmologist or Optometrist _____ Name of Supplier _____ Address of Supplier _____ Signature _____ X Date (D/M/Y) _____ Telephone Number _____	

**PART 3 EMPLOYER/POLICYHOLDER (Only If Authorization Required)**

Employee's/Member's Effective Date (D/M/Y)	Dependant's Effective Date (D/M/Y)	Termination Date(D/M/Y) (if applicable)
Signature of Employer/Plan Administrator Official	Classification	Date (D/M/Y)

X \_\_\_\_\_

**INCOMPLETE INFORMATION WILL MEAN A DELAY IN THE PROCESSING OF THE CLAIM. RETURN COMPLETED FORM TO:  
 VISION CLAIMS, THE CO-OPERATORS, 1920 COLLEGE AVENUE, REGINA SK S4P 1C4**