

VISION CARE STATEMENT OF CLAIM

Ontario Teamsters Benefit Trust Fund

MAIL ALL CLAIM FORMS TO:
BENEFIT PLAN ADMINISTRATORS LIMITED
2 - 1793 Dundas Street East
London, Ontario N5W 3E6

BENEFIT PLAN ADMINISTERED BY:
BENEFIT PLAN ADMINISTRATORS LIMITED

To be completed by Member

Company Name				Local No.	
Member's Name		Identification Number		Date of Birth Day Mo. Yr.	
Member's Address No. and Street City Province Postal Code ()				Telephone No.	
If Dependent Claim, Name of Dependent		Relationship		Sex ☐ M ☐ F Date of Birth Day Mo. Yr.	
DO YOU HAVE ANY OTHER VISION CARE COVERAGE? ☐ YES ☐ NO IF YES, PLEASE COMPLETE					
INSURER'S NAME		GROUP NO.		POLICY NO.	
EMPLOYER'S NAME		IF CLAIM IS FOR A DEPENDENT CHILD INDICATE SPOUSE'S DATE OF BIRTH		Day Mo. Yr.	

To be completed by Supplier

Prescribed by ☐ Ophthalmologist ☐ Optometrist		Patient Name					
Prescription Details		Is this a change in prescription? ☐ Yes ☐ No					
	Sphere	Cylinder	Axis	Prism	Base	Seg Height	Frame and Colour
R							
L							Eye Size
A	R	Tint (Specify Colour & No.)		Type of Bifocal		Type of Trifocal	Manufacturer or Supplier
D							
D	L	1 2					
☐ Plastic ☐ Heat Hardened ☐ Chemically Hardened							
For additional information re: complications etc. 							
Breakdown of extra charges: (e.g. oversize, photogrey, case, etc.) Miscellaneous: 1. \$ 2. \$ 3. \$ 4. \$ Transfer items to misc. below: Amount: 							

Supplier

Day Month Year Date of Service		Charges	
Name		Frame	
Address		Lenses	
City/Town Prov. Telephone No.		Fee	
Postal Code		Misc. 1.	
☐ Optometrist ☐ Optician Signature		Misc. 2.	
		Misc. 3.	
		Total	

PLEASE ATTACH PAID RECEIPT

I certify that the above information is true, correct and complete. I authorize Benefit Plan Administrators Limited ("BPA") to collect and use personal information about me and/or my eligible dependents to process this claim and administer my benefit plan. I am aware BPA will keep my personal information confidential and safeguarded.

I am aware that BPA will only release personal information to my eligible dependents specific to their benefit entitlements. I understand that my personal information (and the personal information of my eligible dependents) may only be shared with health care practitioners, medical facilities, providers of health care/dental services or benefits administration services, provincial health insurance plans, insurance carriers, government agencies, and auditing or independent investigative organizations in order to verify eligibility for my benefit entitlements.

I understand that my social insurance number will be kept in strictest confidence and will only be used for income tax reporting purposes and to match my information with the correct member file. I consent to the collection, use and disclosure of personal information as stated above.

Member's Signature Date (DD / MM / YY)

POSSESSION OF THIS CLAIM FORM DOES NOT CONSTITUTE ELIGIBILITY FOR BENEFITS