



VISION CARE * Please complete in full. Any receipts from supplier must also be submitted.

Plan Member's Name, Policy Number, Certificate Number, Plan Member's Address, Name of Employer, Name of Patient, Date of Birth, Relationship to Plan Member, If patient is a dependent child, please complete: Is he/she attending school full-time?, Is he/she working full-time?, Date schooling will be completed, Is patient covered through any other Group Insurance Plan which provides Optical Benefits?

TO BE COMPLETED BY SUPPLIER

Optical Supplies were furnished by:

Name, Address, Date Glasses/Contacts Ordered, Glasses, Is this the first pair of glasses?, If "No", did prescription change?, If "Yes", did the prescription change in the

Cost of Glasses:

Table with 2 columns: Description (Laboratory Cost of Lenses, Laboratory Cost of Frames, Ophthalmic Dispensing Fee, Eye Examination, Other) and Amount (\$)

Were lenses tinted or photo-grey?, If "Yes", please indicate the cost for this service, Are these a) Prescription sun glasses?, b) Replacement of lost or damaged glasses?

Contact Lenses

Is this the first pair of lenses?, If "No", did prescription change?, If "Yes", did the prescription change in the, Were contact lenses prescribed for severe corneal astigmatism, keratoconus or aphakia?, Can visual acuity be improved up to at least the 20/40 level by contact lenses?, Could visual acuity be improved up to at least the 20/40 level by glasses?

I certify that the information given on this form is true, correct and complete to the best of my knowledge. The claim information willingly provided by me to Equitable Life held in their files, will be used by Equitable Life for the purposes of claims processing and adjudication.

Date

Signature of Supplier

Mailing Instructions - Please keep a copy of your claim form and receipts for your own records.

Mail your completed and signed form with your receipts to our Health Claims department. Please do not use staples.

Equitable Life of Canada
Attn: Group Health Claims Department
One Westmount Road North
P.O. Box 1604 Waterloo, Ontario N2J 0A7

Alternatively, you can scan and email your claim forms, with receipts as attachments, to 'group-health-claims@equitable.ca'. Or fax your documents to 519.883.7406 or toll-free to 1.888.505.4373.