THE Great-West Life ASSURANCE COMPANY

STATEMENT OF COVERED EXPENSES
FOR SUPPLEMENTARY HEALTH BENEFITS
L.I.U.N.A. LOCAL 183
RETIREE BENEFIT PROGRAM

MAIL ALL CLAIMS TO: **LOCAL 183 TRUST ADMINISTRATION**
1263 WILSON AVENUE, SUITE 205
NORTH YORK, ONTARIO M3M 3G2
CLAIM ENQUIRIES: **416.240.7487**

Please type or print, including all information indicated. Use more than one form if necessary.

Member's Name	Policy No.	Identification No.	Date of Birth Mo. Day Yr.
Member's Address No. and Street City Prov. Postal Code			☐ Initial Claim ☐ Subsequent Claim

Have you (or your dependant) any other coverage which would pay a benefit for this claim? ☐ Yes ☐ No

If "Yes", policy number _____ and name of insuring agency _____

	FIRST NAME	SEX	DATE OF BIRTH			DATE EXPENSE INCURRED	NAME AND ADDRESS OF SUPPLIER OF PHARMACY	DRUGS: NAME OR D.I.N. OTHER: TYPE OF EXPENSE	AMOUNT CHARGED
			D	M	Y				
MEMBER									
SPOUSE									

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan.

I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life, located within or outside Canada, to exchange personal information when necessary for these purposes. I authorize the use of my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the plan. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge.

Plan Member's Signature _____ Date _____

YOUR CLAIM CANNOT BE PROCESSED UNLESS ALL QUESTIONS ARE ANSWERED IN FULL

M635D(158000-R)-12/09

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THE Great-West Life ASSURANCE COMPANY

VISION CARE STATEMENT OF CLAIM
L.I.U.N.A. LOCAL 183
RETIREE BENEFIT PROGRAM

MAIL ALL CLAIMS TO: LOCAL 183 TRUST ADMINISTRATION
1263 WILSON AVENUE, SUITE 205
NORTH YORK, ONTARIO M3M 3G2
CLAIM ENQUIRIES: 416.240.7487

To be completed by member

PLEASE ATTACH THE PAID RECEIPT

Member's Name	Policy No.	Identification No.	Date of Birth Mo. Day Yr.
Member's Address No. and Street City Prov. Postal Code			Telephone No.
If Dependant Claim, Name of Dependant	Relationship	Sex ☐ M ☐ F	Date of Birth Mo. Day 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 _____

☐ Initial Claim
☐ Subsequent Claim

Date Signature of Member

TO BE COMPLETED BY SUPPLIER

Prescribed by ☐ Ophthamologist ☐ Optometrist **Is this a change in prescription?** ☐ Yes ☐ No

Prescription Details

		Sphere	Cylinder	Axis	Prism	Base	P.D.	Seg Height	Frame and Colour		
R							FAR		Eye Size	DBL	Temple
L							NEAR				
ADD			Tint (Specify Colour & No.)		Type of Bifocal		Type of Trifocal		Manufacturer of Supplier		
	R										
	L		1 2								

☐ Plastic ☐ Heat Hardened ☐ Chemically Hardened

For additional information re complications ect.

Breakbown of extra charges:
(e.g. oversize, photogrey, case, ect.)
Miscellaneous:

Transfer items to misc. below
Amount:

1. _____ $ _____
2. _____ $ _____
3. _____ $ _____
4. _____ $ _____
Total _____

Supplier Day ☐☐ Month ☐☐ Year ☐☐
Date of service

Name

Address

City/Town Prov. Telephone No.

Postal Code ☐☐☐ ☐☐☐

☐ Optometrist ☐ Optician

Charges
Frames
Lenses
Fee
Misc. 1.
Misc. 2.
Misc. 3.
Total

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I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life, located within or outside Canada, to exchange personal information when necessary for these purposes. I authorize the use of my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the plan. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge.

Plan Member's Signature _____ Date _____

YOUR CLAIM CANNOT BE PROCESSED UNLESS ALL QUESTIONS ARE ANSWERED IN FULL

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Clear

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