Visioncare Claim Statement

Instructions: Attach the bills and receipts for all expenses and itemize them by providing all the information requested. Note: All bills and receipts are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or explanation for Income Tax purposes. **Please answer all questions.** This claim will be returned to you if it is incomplete or contains errors.

Employees Last & First Name	❑ Male ❑ Female	Date of Birth (mmm/dd/yyyy)	Policy/Group #:
Employee **HOME** Mailing Address	Employer/**COMPANY** Name		Employee/Cert #:
	Email:		
	Work Ph.	Home Ph.	

• Are you or your dependents entitled to receive comparable benefits from any other insuring company?	□ Yes	□ No
If yes, complete the following:		
• Does your spouse work for the same employer?	□ Yes	□ No
If yes, indicate his/her name: _____ Identification No: _____		
• Are you or your dependent(s) entitled to benefits under any other group insurance plan?	□ Yes	□ No
If yes, indicate name of other group insurer _____ Policy No: _____ Name of Family Member Insured _____		
• Is treatment required as the result of an accident?	□ Yes	□ No
• If yes, give date, location, and explain how accident happened _____		
• Is claim being made for Workers Compensation Benefits?	□ Yes	□ No
• If patient is a dependent child, please provide spouse's date of birth (mmm/dd/yyyy) _____/_____/_____		

Please separate all eligible expenses by <u>claimant</u> and attach original receipts

Please **<u>add</u>** all expenses together for **<u>each</u>** member submitting claims on this form

All dental expenses must be submitted using a standard dental claim form provided by your practitioner.

NAME OF PATIENT	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH (MMM/DD/YYYY)	CLAIN DETAILS # OF RECEIPTS	CLAIN DETAILS VISION EXPENSES
		TOTAL CHARGES		**$**

I authorize any portion of the claimed item(s) not paid by my health plan to be reimbursed from my **Health Spending Account.**	❑

Protecting your personal information: At ProBenefits Inc., we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of ProBenefits or the offices of an organization authorized by ProBenefits. We limit access to personal information to your file to ProBenefits staff or persons authorized by ProBenefits who require it to perform their duties, to persons whom you have granted access, and to persons authorized by law. We use the personal information to determine your eligibility for coverage and to administer the group benefits plan.

Name of Employee (Please Print)	Signature of Employee	Date

ProBenefits Inc.

employer benefit solutions

PBI OFFICE USE ONLY
Cheque #:
Date:
Cheque Amount:

SUBMIT CLAIMS TO:
Mail: #8 4402 37 Street Stony Plain AB T7Z 2A9
E-mail: claims@probenefitsinc.ca

CONTACT US:
Ph. 780 963 5230 Toll Free. 800 375 3360
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