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.

P	· ·	•							
Employees Last & First Name		☐ Male☐ Female	Date of	Birth (mm	cy/Group #:				
Employee HOME Mailing Address		Employer/COMPANY Name				Emp	Employee/Cert #:		
		Email:							
		Work Ph. Home Ph.							
Are you or your dependents entitled to company?		receive comparable benefits from any ot			ner insur	ing	□ No		
If yes, complete the fo	llowing:								
							□ Yes	- No	
Does your spouse	mployer?						□ No		
If yes, indicate his/her		Identification No:							
Are you or your de	to benefits un	nefits under any other group insurance plan? □ Yes □ No							
If yes, indicate name of other group insurer	Policy No	Policy No: Nam			ne of Family Member Insured				
	ired as the result of a	an accident?		-			□ Yes	□ No	
-	ocation, and explain		nappened						
	, , , , , , , , , , , , , , , , , , ,								
Is claim being mad	ensation Bene	ion Benefits?				□ Yes	□ No		
If patient is a deperture of the second	provide spouse	e's date of birth (mmm/dd/yyyy)/			/ /				
Ples	ase separate all eligi	hle evnenses h	v claimar	nt and at	tach origin	al recei	nts		
							J 1.3		
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.									
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