

VISION CARE STATEMENT OF CLAIM

MAIL ALL CLAIM FORMS TO:
 BENEFIT PLAN ADMINISTRATORS (ATLANTIC) LIMITED
 38 Solutions Drive, Suite 100
 Ravine Centre Two
 Halifax, Nova Scotia B3S 0H1

BENEFIT PLAN ADMINISTERED BY:
 BENEFIT PLAN ADMINISTRATORS (ATLANTIC) LIMITED

To be completed by Member

Company Name				Local No.			
Member's Name			Identification Number			Date of Birth	
						Day Mo. Yr.	
Member's Address						Telephone No.	
No. and Street		City		Province		Postal Code	
						()	
IS THIS A CHANGE OF ADDRESS FROM YOUR LAST CLAIM SUBMISSION: YES() NO (). IF YES, PLEASE ADVISE EFFECTIVE DATE OF CHANGE: DD / MM / YY							
If Dependent Claim, Name of Dependent				Relationship		Sex	Date of Birth
						<input type="checkbox"/> M <input type="checkbox"/> F	Day Mo. Yr.
DO YOU HAVE ANY OTHER VISION CARE COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> 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							Eye Size
L							
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.)	Transfer items to misc. below:
Miscellaneous:	Amount:
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
4. _____	\$ _____

Supplier Day Month Year <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> </div> <p style="text-align: center; font-size: small;">Date of Service</p> <hr/> Name _____ Address _____ City/Town _____ Prov. _____ Telephone No. _____ Postal Code <input type="checkbox"/> Optometrist <input type="checkbox"/> Optician Signature _____	<p style="text-align: center; font-weight: bold;">Charges</p> <hr/> Frame <hr/> Lenses <hr/> Fee <hr/> Misc. 1. <hr/> Misc. 2. <hr/> Misc. 3. <hr/> Total
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PLEASE ATTACH PAID RECEIPT

I certify that the above information is true, correct and complete. I authorize Benefit Plan Administrators (Atlantic) 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) _____