IUPAT Local 177 Welfare Trust Fund
Vision Claim Form

Use a separate form for each family member. Attach the original receipts for all expenses. Receipts will not be returned, as a copy of the Explanation of Benefits is sent to you and copies of receipts are sufficient for income tax purposes or coordination of benefits with other group plans.

Your claim will be returned to you if the claim form is incomplete.

Member Information Section

Group Number	Certificate Number	Gender			Language Preference	
59315		☐ Male	☐ Female	☐ Other	☐ English	☐ French

Last Name	First Name	Date of Birth
		Month Day Year

Mailing Address	City	Province	Postal Code

Phone Number	Cell Phone	Email Address

Patient Information Section

Patient's Name	Relationship to Member	Patient's Date of Birth
		Month Day Year

If Dependent, does the patient reside with you?		☐ Yes	☐ No	
If child is 18 years of age or older	a) Full-time Student?	☐ Yes	☐ No	If yes, how many hours per week at school? _____
	b) Employed?	☐ Yes	☐ No	If yes, how many hours per week? _____

Coordination of Benefits Section

Are you or any other member of your family entitled to benefits under any other plan?	☐ Yes	☐ No
If yes, name of family member insured:	Relationship to employee:	
Name of other insurance company:	Policy Number:	
Is the treatment required as the result of an accident?	☐ Yes	☐ No
If yes, indicate the accident date, location, and details on how the accident occurred.		
Is the treatment required as the result of a work-related injury?	☐ Yes	☐ No
If yes, is a claim being made for Worker's Compensation Benefits?	☐ Yes	☐ No

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1050-11150 Jasper Ave NW, Edmonton AB T5K 0C7
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Materials Section
** Must Be Completed By the Provider **

Date of Service: Month Day Year			**Type of Lenses Supplied**			**Reason for Purchase**	
Charges For Materials Supplied	Frames	$		Left Eye	Right Eye	A. Initial Prescription	
	Lens for Right Eye	$	Plain Glass			B. Prescription change	
	Lens for Left Eye	$	Single Vision			C. Loss or breakage	
	Contact Lenses	$	Bifocal			D. Prescription Sunglasses (provide tint and color no.)	
	Safety Glasses	$	Trifocal			E. Safety Glasses	
	Other *	$	Contact			F. Other (Please Explain)	

* Give reasons and specific item cost for “Other” in area 1 (e.g., hardening, tinting, varigray, oversize lenses, etc.)

If glasses are tinted, what was the tint?

Was a deposit made? ☐ Yes ☐ No If yes, please indicate the amount of the deposit: $

Name of Prescribing Optometrist or Ophthalmologist – if signed by Optician

I am legally qualified ☐ Ophthalmologist ☐ Optometrist ☐ Optician

Signed: _____ Date: Month Day Year

Address: _____ Phone Number: _____

Payment Assignment Section
** To Assign Payment Directly to Supplier **

I hereby assign my benefits payable from this claim to _____ and authorize payment directly to the supplier.
Name of Supplier

Member Signature: Date: Month Day Year

Authorization—Signature Required Below

I hereby authorize any healthcare provider, my plan administrator, my employer, insurance companies, other organizations, or benefit service providers working with Ellement Consulting Group to exchange information when necessary for the purpose of settlement of this claim and to administer the group plan. I authorize release of the information contained in this claim form to the Insurer/Plan Administrator, its authorized representative or consultant for the purpose of settlement of this claim. I understand the information collected is kept in strict confidence and used solely for the purpose of assessing the claim and to administer the group benefit plan. I certify that the information given is true, correct, and complete to the best of my knowledge and that each of the above expenses are for medical treatment that I and/or my dependents received. I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to the supplier for the entire amount.

_____ Month / Day / Year _____

Signature of Member **Date Signed**

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