

INSTRUCTIONS: Complete a separate form for each family member for whom you are claiming expenses. Attach bills for each expense and fully itemize them in the space provided below.
IMPORTANT: If any of the requested information is missing or incorrect, your claim will be returned. All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

NAME OF GROUP _____ POLICY NUMBER _____

EMPLOYEE NAME _____

EMPLOYEE ADDRESS _____ POSTAL CODE _____

EMPLOYEE ID NUMBER _____ DIVISION NUMBER _____

NAME OF PATIENT _____ DATE OF BIRTH ____/____/____
DAY MONTH YEAR RELATIONSHIP TO EMPLOYEE _____

1. If Dependent, does the patient reside with you? Yes No

2. If child 18 years or older:

A. FULL-TIME STUDENT? Yes No

B. If student, how many hours per week at school? _____

C. EMPLOYED? Yes No If Yes, how many hours worked per week? _____

3. Are you or any member of your family entitled to benefits under any other Group Insurance? Yes No

If Yes, name of family member insured _____

Name and address of other _____

Insurance Company _____ Policy No. _____

4. Is any member of your family (other than yourself) insured as an employee under this policy? Yes No

If Yes, Name of family member _____

5. If Yes to question 3 or 4 above, and patient is a dependent child, give employee's birthdate ____/____/____
DAY MONTH

AND spouse's birthdate ____/____/____
DAY MONTH

TO BE COMPLETED BY PROVIDER OF MATERIALS

<p>1. Date of Service _____</p> <p>Frames \$ _____</p> <p>CHARGES FOR LENS FOR RIGHT EYE \$ _____</p> <p>SUPPLIED: LENS FOR LEFT EYE \$ _____</p> <p>Other \$ _____</p> <p>TOTAL \$ _____</p>	<p>2. Type of lenses supplied</p> <table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: center;"><small>Left Eye</small></td> <td style="text-align: center;"><small>Right Eye</small></td> </tr> <tr> <td>Plain glass</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Single vision</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Bifocal</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Trifocal</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Contact</td> <td>_____</td> <td>_____</td> </tr> </table>		<small>Left Eye</small>	<small>Right Eye</small>	Plain glass	_____	_____	Single vision	_____	_____	Bifocal	_____	_____	Trifocal	_____	_____	Contact	_____	_____	<p>3. Reason for purchase (please check)</p> <p>a) Initial prescription _____</p> <p>b) Prescription change _____</p> <p>c) Loss or breakage _____</p> <p>d) Other (please explain) _____</p>
	<small>Left Eye</small>	<small>Right Eye</small>																		
Plain glass	_____	_____																		
Single vision	_____	_____																		
Bifocal	_____	_____																		
Trifocal	_____	_____																		
Contact	_____	_____																		

4. Give reasons and specific item cost for "Other" in area 1. e.g. hardening, tinting, varigray, oversize lenses, etc.

If glasses tinted, what was tint? _____

5. Name of Prescribing Optometrist or Ophthalmologist – if signed by Optician

I am a legally qualified OPHTHALMOLOGIST OPTOMETRIST OPTICIAN

SIGNED _____ DATE _____ TELEPHONE # _____

ADDRESS _____

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 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 certify that the information given is true, correct and complete to the best of my knowledge.

EMPLOYEE'S SIGNATURE _____ DATE _____