

Vision Care Claim Form

Group Claims, PO Box 3425 Stn D, Ottawa, ON K1P 1G9

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies is committed to keeping information concerning this claim confidential.

1 Patient information

Name - first and last		
Sex of Dependent <input type="checkbox"/> Male <input type="checkbox"/> Female		
Relationship to Subscriber		
Date of Birth	<input type="text"/> <input type="text"/> <input type="text"/>	
	Day	Month Year

Do you have any other vision care coverage? Yes No

If yes, please complete

Insured's Name	Group No.	Policy No.	Employer's Name
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2 Subscriber information

Name of Employer General Motors of Canada Ltd.		
Group Number 83129	Identification Number	
Subscriber's Name - first and last		Date of birth (d/m/y)
Address		
City	Province	Postal Code

3 To be completed by supplier

APPROVAL NO: _____

PRESCRIBED BY OPTHALMOLOGIST OPTOMETRIST

PRESCRIPTION DETAILS

	SPHERE	CYLINDER	PRISM	
R				FRAME AND COLOUR
L				EYE SIZE
A R	TINT SPECIFY	TYPE OF BIFOCAL	TYPE OF TRIFOCAL	MANUFACTURER OR DISPENSER
D L	1 2 3			

PLASTIC HEAT HARDENED CHEMICALLY HARDENED OTHER (SPECIFY)



4 Supplier identification

Registration No.	Date of Service	<input type="text"/> <input type="text"/> <input type="text"/>
	Day	Month Year
Name		
Address		
City	Province	Postal Code
Licence No.		
Signature of Optometrist X		

CHARGES	For Sun Life Use Only	
	OVERRIDE CODE	MESSAGE CODE
FRAME		
LENSES		
FEE		
MISC		
TOTAL		
DEDUCTIBLE / SHARED RISK		
NET TOTAL		

5 Patient / guardian declaration

I understand that the charges listed in this claim may not be covered by or may exceed my agreement benefits. I understand that I am financially responsible to my supplier for the cost of those services. I authorize Sun Life to conduct any necessary investigation concerning this claim; use any personal information collected about me for the adjudication of any claim I may make and for the administration of my group benefit plan; release personal information about me to my employer as needed to administer my group benefit plan; release information about me to any agent or third party where necessary for the proper adjudication of my claim or administration of my group benefit plan.

Signature of patient/guardian
X

6 Subscriber declaration

I hereby assign my benefits payable from this claim to the above named dispensary and authorize payment directly to him.

Signature of subscriber
X