Manulife Financial

LIFE
A BENEFIT PLAN FOR FIRST NATIONS

Group Benefits
Assignment of Vision Care Claim

To be completed by the plan member unless otherwise indicated. Original receipts must be attached for all expenses. (Please attach to the back of this form.) Please retain copies for your files as original receipts will not be returned.

1 Plan member information

You can obtain your plan number, account/division number and your certificate number from your I.D. card.

Plan contract number	**Account/Division number**	**Plan member certificate number**	Plan sponsor

Plan member name (first, middle initial, last)	Date of birth (dd/mmm/yyyy)

Plan member address (number, street and apt.)	City or town	Province	Postal code

Are these expenses eligible for coverage under any type of workers' compensation board? ◯ Yes ◯ No

Are you, your spouse or dependants covered under any other plan for the expenses being claimed?

◯ Yes ◯ No

If "Yes," please retain photocopies of all receipts submitted with this claim for submission to your secondary carrier. If this is your first claim, or if information has changed, please provide the following:

Spouse's date of birth (dd/mmm/yyyy)	Name of spouse's insurance company	Spouse's plan contract number	Spouse's plan member certificate number

2 Patient information

Complete for all expenses. Use one line per patient.

Patient's name	**Date of birth** (dd/mmm/yyyy) (1st Claim only)	**Relationship to plan member** (1st Claim only)	**School and city**	**If employed, hrs worked per week**

3 Vision care expenses

To be completed by supplier.

Please enclose an itemized receipt indicating:

- patient's name,
- cost of contact lenses,
- cost of glasses,
- dispensing fee,
- cost of eye exam,
- date of eye exam,
- cost of tinting,
- cost of laser surgery and
- date dispensed.

Medically necessary contact lenses:

Please have the supplier complete and sign below.

Were contact lenses prescribed for severe corneal astigmatism, keratoconus or aphakia? ◯ Yes ◯ No

Can visual acuity be improved by at least 2 lines on the Snellen chart over the best possible vision with glasses? ◯ Yes ◯ No

Could visual acuity be improved up to at least the 20/40 level by glasses? ◯ Yes ◯ No

Date dispensed (dd/mmm/yyyy)

◯ Optician ◯ Optometrist ◯ Ophthalmologist	Company name

Street address	City or town	Province

Postal code	Phone number	Total charges billed to insurer
	( )	$

For direct payment to the dispenser by Manulife Financial, the following must be read and signed.
I hereby certify that the information on this form as well as on the documents attached, is true, accurate and complete.
I certify that the glasses/lenses dispensed conform to the attached patient's prescription.

Signature of Optician/Optometrist/Ophthalmologist	Date signed (dd/mmm/yyyy)

Please complete next page.

4 Claims confirmation

NOTE - ORIGINAL RECEIPTS must be attached for all expenses.

Total amount of ALL receipts submitted **$**

Please sign only on the date you pick up your product, you are satisfied with the product and, the form is completed.

I hereby assign my benefits payable from this claim to the named optician, optometrist or ophthalmologist and authorize payment directly to him/her.

I understand that the charges listed in this claim may not be covered by or may exceed my plan benefits. **I understand** that I am financially responsible to my dispensary for the cost of those services.

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). **I am authorized** by my Dependants to disclose and receive their Information, for the Purposes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid. **I understand** that Manulife's Privacy Policy and Privacy Information Package are available at www.manulife.ca/groupbenefits, or from my Plan Sponsor.

Please sign here

Signature of plan member	Date signed (dd/mmm/yyyy)

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits health file. Access to your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

5 Mailing instructions

Please mail your completed claim form and receipts to the appropriate address.

If you live outside Quebec:
Manulife Financial Group Benefits
Health Claims
PO BOX 1653
WATERLOO ON N2J 4W1

If you live in Quebec:
Manulife Financial Group Benefits
Health Claims
P.O. BOX 2580, STATION B
MONTREAL QC H3B 5C6