Manulife Financial

VISION CARE STATEMENT OF CLAIM

INTERNATIONAL UNION OF PAINTERS AND ALLIED TRADES WELFARE FUND

MAIL ALL CLAIMS TO: **IUPAT Benefit Trust Administration**
P. O. Box 1280, Station B
Mississauga, ON L4Y 3W5

SF-6122

To be completed by member

PLEASE ATTACH THE PAID RECEIPT

Employer	Employer location (city and prov.)

Member's Name	Identification No.	Date of Birth Mo. Day Yr.

Member's Address
No. and Street City Prov. Postal Code

Telephone No.

Is this a change of address from your last claim submission? ☐ Yes ☐ No If yes, please advise effective date of change _____ mm/dd/yy

PLEASE NOTE ALL FUTURE IUPAT BENEFIT TRUST CORRESPONDENCE WILL BE DIRECTED TO THE ABOVE ADDRESS.

If Dependant Claim, Name of Dependant	Relationship	Sex ☐ M ☐ F	Date of Birth Mo. Day Yr.

DO YOU HAVE ANY OTHER VISION CARE COVERAGE? ☐ YES ☐ NO ☐ IF YES, PLEASE COMPLETE:

INSURER'S NAME _____ GROUP NO. _____ POLICY NO. _____

EMPLOYER'S NAME _____

IF YES, AND CLAIM IS FOR A DEPENDENT CHILD, PLEASE INDICATE SPOUSE'S DATE OF BIRTH. _____

☐ Initial Claim
☐ Subsequent Claim

Date Signature of Member

TO BE COMPLETED BY SUPPLIER

Prescribed by Prescription Details ☐ Ophthalmologist ☐ Optometrist

Patient Name _____

Is this a change in prescription? ☐ Yes ☐ No

		Sphere	Cylinder	Axis	Prism	Base	P.D.	Seg Height	Frame and Colour
R							FAR		Eye Size / DBL. / Temple
L							NEAR		

		Tint (Specify Colour & No.)	Type of Bifocal	Type of Trifocal	Manufacturer or Supplier
ADD	R				
	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. _____ $ _____

Total _____

Supplier

Day Month Year

Date of service

Name

Address

City/Town Prov. Telephone No.

Postal Code

☐ Optometrist ☐ Optician

Signature

Charges	
Frame	
Lenses	
Fee	
Misc. 1.	
Misc. 2.	
Misc. 3.	
Total	

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") and/or its authorized representative 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 and/or its authorized representative, 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 administrator.

Plan Member's Signature: _____ **Telephone Number:** _____ **Date:** _____

Any information provided to or collected by Manulife and/or its authorized representative in accordance with this authorization, will be kept in a Group Benefits health file. Access to your information will be limited to:

- Manulife employees, authorized 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.

YOUR CLAIM CANNOT BE PROCESSED UNLESS ALL QUESTIONS ARE ANSWERED IN FULL
PLEASE ENCLOSE PAID RECEIPT