Plumbing and Pipefitting Workers Local 170
Welfare and Pension Plan
SUITE 203 - 1658 FOSTER'S WAY, DELTA, BC V3M 6S6
604-526-3434 | 1-800-665-6808
WWW.PLUMBERS.BC.CA

Vision Care Claim Form

MEMBER FIRST & LAST NAME		MEMBER SIN #
MEMBER ADDRESS	CITY	POSTAL CODE

ORIGINALS MUST BE SUBMITTED FOR PROCESSING, otherwise will be returned to the Member

☐ **H.S.A.** IF YOU ARE ELIGIBLE FOR AN H.S.A. REIMBURSEMENT PLEASE CHECK BOX TO HAVE YOUR CLAIM FORWARDED FOR REIMBURSEMENT THROUGH COUGHLIN.

EYE EXAMS:

Name of Claimant	Date of Service			Amount of Purchase	Other Carrier Amount	Invoice #
	JAN	1	2017			
	mmm	dd	yyyy			
	mmm	dd	yyyy			
	mmm	dd	yyyy			
	mmm	dd	yyyy			

VISION CARE PRESCRIPTIONS: (GLASSES & CONTACTS)

Name of Claimant	Date of Service			Amount of Purchase	Other Carrier Amount	Invoice #
	JAN	1	2017			
	mmm	dd	yyyy			
	mmm	dd	yyyy			
	mmm	dd	yyyy			
	mmm	dd	yyyy			

LASER EYE SURGERY:

Name of Claimant	Date of Service			Amount of Purchase	Other Carrier Amount	Invoice #
	JAN	1	2017			
	mmm	dd	yyyy			

IMPORTANT NOTES

A spouse who is covered by another benefit plan must first submit a claim to his/her insurer.
Claims for children must be submitted to the insurer of the parent whose birthday occurs first in the calendar year.
Afterwards, complete this form and provide a copy of the settlement provided by any other benefit plan. For this type of claim, photocopies are acceptable.

☐ Are any of the benefit claims listed above, covered by any other benefit plan or group plan? If yes, please check the box and provide all details for the settlement from all other benefit plans.

Company Name & Identification Number

I AUTHORIZE

My personal physician and any health care professional, public, private health or social services organization, insurer, reinsurer, employer, or other private organization or personal that has record or knowledge of me or my health, or any of my minor children being insured or their health, to give any such personal information to the Plan Administrator/Insurer, it's reinsurers, or any consumer reporting agency acting on it's behalf, for assessment of claims, and benefit administration.

The use of my Social Insurance Number (SIN) for claim identification purposes (Member Only) and, as required by law for Income Tax reporting.
A copy of this authorization shall be as valid as the original

MEMBER'S SIGNATURE / DATE SIGNED

#MoveUp