VISION CARE CLAIM FORM

UA LOCAL 170 HEALTH & WELLNESS PLAN

#203 – 1658 Fosters Way, Delta, B.C., V3M 6S6 / www.plumbers.bc.ca / **info@plumbers.bc.ca**

To process your reimbursement, this is a 2-sided form that must be completed, then signed by **Plan Member**.

MEMBER INFORMATION

☐-**Change of Address**

Member **First, Middle Initial, Last Name**		Member **Social Insurance Number** (S.I.N.) *optional to complete S.I.N.*
Member **Mailing Address**	City & Province	Postal Code

EYE EXAMINATION(S)

additional* eye examinations for specific medical conditions to be completed on other side of form

Name of Claimant	Date of Service (day/month/year)	Purchase Amount ($)	Other Insurer Amount ($)	Invoice #

PRESCRIPTIVE VISION CARE (Glasses & Contacts)

visual therapy, corrective contact lens claims to be completed on other side of form

Name of Claimant	Date of Service (day/month/year)	Purchase Amount ($)	Other Insurer Amount ($)	Invoice #

LASER EYE SURGERY

Name of Claimant	Date of Service (day/month/year)	Purchase Amount ($)	Other Insurer Amount ($)	Invoice #

COORDINATION OF BENEFITS

Are any of the benefits claims listed above, covered by any other benefit plan or group plan? ☐-No ☐-Yes ➔	If **YES**, please provide all details for the settlement from all other benefit plans.

☐-Yes, I have attached other insurer's Statement of Benefit with this claim.

Important notes for claiming procedures:

- A Spouse or Common-Law who is covered by another benefit plan must submit their claim(s) to their insurer first.
- Dependent (child/children) claims must be submitted to the insurer of the parent whose birthday occurs **first** in the calendar year.
- Copy of other insurer's Statement of Benefit along with this completed form may be submitted to the UA Local 170 H&W Plan Office for processing.
- Vision Care Expenses incurred in the current year must be **received by the UA Local 170 H&W Plan office no later than JUNE 30** of the following year.

Healthcare Spending Account (H.S.A.)

H.S.A. -☐ ← Please check box if you are eligible for an H.S.A. and would like your claim to be processed under the Healthcare Spending Account.

➔ ➔ If the H.S.A box is NOT checked off, the H&W Office DOES NOT follow up and WILL NOT process the claim using H.S.A. ← ←

Important note:

- Eligible H.S.A. claims are **processed under the regular Vision Care benefit first**, then processed under the Healthcare Spending Account.
- H.S.A. claims: Expenses incurred during the H.S.A. allotment period are due in the UA Local 170 H&W Plan Office by JUNE 30.

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Eye Examination(s) FOR SPECIFIC MEDICAL CONDITIONS

Qualifying medical conditions for additional eye examination: diabetes, glaucoma, retinopathy, dry eye disease, macular degeneration.

Name of Claimant	Date of Service (day/month/year)	Purchase Amount ($)	Other Insurer Amount ($)	Invoice #

Corrective Contact Lens WITH MEDICAL REFERRAL

Name of Claimant	Date of Service (day/month/year)	Purchase Amount ($)	Other Insurer Amount ($)	Invoice #

VISUAL TRAINING

Name of Claimant	Date of Service (day/month/year)	Purchase Amount ($)	Other Insurer Amount ($)	Invoice #

AUTHORIZATIONS AND DECLARATIONS

Authorizations and Declarations:

- I authorize that my personal physician and any health care professional, public, private health or social services organization, insurer, employer, or other private organization or personal that has record or knowledge of me or my health, or Spouse/Common-Law or any of my Dependent(s) 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.
- I authorize UA Local 170 H&W Plan to use my social insurance number to administer my coverage and benefits under the group benefits plan, and, as required by law for Income Tax reporting.
- I agree that a photocopy or electronic copy of this Authorization and Declarations section is as valid as the original.
- I understand that Vision Care benefits are intended to be used towards the purchase and/or repair of prescriptive eyewear or prescriptive lenses prescribed by an Optometrist or Physician.
- I understand that Vision Care reimbursements are subject to reasonable and customary (R&C) charges. This includes the frequency of purchases that is considered reasonable in a certain time period.
- Unauthorized claim: I authorize the Trustees of the UA Local 170 Health & Wellness Plan and Coughlin & Associates Ltd. to disclose to my Employer and Union my personal information, including information relating to my benefit enrollment and benefit claim assessment, if the UA Local 170 Health & Wellness Plan Trustees or Coughlin & Associates Ltd. reasonably believe that I submitted or authorized the submission of a claim for a benefit from the UA Local 170 Health & Wellness Plan, whether for myself my Spouse/Common-Law Spouse or my Dependents, to which I knew or ought to have known was not entitled.
- I understand that Vision Care claims are randomly audited and I agree to retain all original receipts pertaining to my claim(s) for 12-months. I understand that the UA Local 170 H&W Plan may require me to provide any original claim receipts and any supporting documents for verification when requested.

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

Plan Member Signature:
Date (day/month/year)

This claim is incomplete, if NOT signed.

Paper submission: This claim is not complete, if it is not signed.

Electronic submission: by typing your name, you are signing this claim electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this claim.

Please complete and return to:

UA Local 170 H&W Plan #203 – 1658 Fosters Way, Delta, B.C., V3M 6S6

or by Email: info@plumbers.bc.ca