Equitable Life of Canada®

Head Office
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VISION CARE * Please complete in full. Any receipts from supplier must also be submitted.

Employee's Name	Policy Number	Certificate Number

Employee's Address (street, city, province, postal code)

Name of Patient	Date of Birth	Relationship to Employee

If patient is a dependent child, please complete:
Is he/she attending school full-time? ☐ Yes ☐ No
Date schooling will be completed:_____ (DD /MM /YYYY)
Is he/she working full-time? ☐ Yes ☐ No
Is he/she working part-time? ☐ Yes ☐ No

Name of Employer

Is patient covered through any other Group Insurance Plan which provides Optical Benefits? ☐ Yes ☐ No If yes, give details:

_____ date

_____ Employee's signature

TO BE COMPLETED BY SUPPLIER

Optical Supplies were furnished by:

Name _____ Address _____

Date Glasses/Contacts Ordered _____

Glasses

Is this the first pair of glasses? ☐ Yes ☐ No If "No", did prescription change? ☐ Yes ☐ No Change
If "Yes", did the prescription change in the ☐ Right Eye? ☐ Left Eye?

Cost of Glasses:

Laboratory Cost of Lenses (including Tinting or Photo-grey)	$ _____
Laboratory Cost of Frames	$ _____
Ophthalmic Dispensing Fee	$ _____
Eye Examination (if not paid by Provincial Plan)	$ _____
Other _____ (please specify)	$ _____
TOTAL	**$** _____

Were lenses tinted or photo-grey? ☐ Yes ☐ No
If "Yes", please indicate the cost for this service.
$_____

Are these
a) Prescription sun glasses? ☐ Yes ☐ No
b) Replacement of lost or damaged glasses? ☐ Yes ☐ No

Contact Lenses

Is this the first pair of lenses? ☐ Yes ☐ No **Total Cost $** _____
If "No", did prescription change? ☐ Yes ☐ No Change
If "Yes", did the prescription change in the ☐ Right Eye? ☐ Left Eye?
Were contact lenses prescribed for severe corneal astigmatism, keratoconus or aphakia? ☐ Yes ☐ No
Can visual accuity be improved up to at least the 20/40 level by contact lenses? ☐ Yes ☐ No
Could visual acuity be improved up to at least the 20/40 level by glasses? ☐ Yes ☐ No

I certify that the information given on this form is true, correct and complete to the best of my knowledge. The claim information willingly provided by me to Equitable Life held in their files, will be used by Equitable Life for the purposes of claims processing and adjudication. I understand and authorize that for the above purposes the personal information on file is accessible to, and may be exchanged with, authorized employees of, and relevant third parties retained by Equitable Life, its sales distribution network, participating reinsurer(s), other insurance companies, investigative organizations, health care providers, including, but not limited to, pharmacies, physicians, dentists, and any other person or party whom I authorize. If applying for my spouse and/or dependents, I confirm that I am authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and communication of their personal information for the same purposes. I understand that claims made under the Group Insurance Policy are submitted through me as the plan member. I therefore authorize Equitable Life to exchange information about these claims with me or any person acting on my behalf, including a spouse or dependent, as deemed necessary for the purpose of confirming eligibility and assessing and managing the claim.

_____ Date

_____ Signature of Supplier