

VISION CARE CLAIM FORM



Please Return Completed Claims To:
 Rice Financial Group Inc.
 491 Portage Ave.
 Wpg., MB. R3B 2E4
 Phone: (204) 788-4040 OR
 1-800-665-1234 within Canada

INSTRUCTIONS:

- THIS FORM IS TO BE USED FOR VISION CARE BENEFITS FOR CORRECTIVE EYEGLASSES/CONTACT LENSES AND EYE EXAMINATIONS.
- BENEFITS PAYABLE SHALL BE DETERMINED BY THE MAXIMUMS AND FREQUENCY LIMITATIONS CONTAINED IN THE COVERAGE AGREEMENT.
- PLEASE COMPLETE ALL SECTIONS OF THE CLAIM FORM.
- PLEASE ATTACH AN ITEMIZED RECEIPT OR INVOICE.
- EFFECTIVE JANUARY 1, 2000, RECEIPTS WILL NO LONGER BE RETURNED
- PATIENTS 65 YEARS OF AGE AND OLDER, PLEASE ATTACH MANITOBA HEALTH CHEQUE STUB.

TO BE COMPLETED BY EMPLOYEE:				(PLEASE PRINT CLEARLY)			
CERTIFICATE NO. 10		POLICY		SURNAME OF PATIENT		GIVEN NAME AND INITIAL OF PATIENT	
						DATE OF BIRTH DAY MONTH YEAR	
EMPLOYEE ADDRESS		CITY/TOWN		PROVINCE			
EMPLOYEE NAME: LAST		FIRST				DATE OF BIRTH DAY MONTH YEAR	
PRESCRIPTION EYEGLASSES/CONTACT LENSES				ARE ANY BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER VISION CARE COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF BLUE CROSS IS SECOND INSURER PLEASE ATTACH A STATEMENT OF PAYMENT OR DENIAL FROM 1ST INSURER. IF YES, COMPLETE THE FOLLOWING: CONTRACT HOLDER OF OTHER PLAN _____ BIRTHDATE _____ DAY / _____ MONTH / _____ YEAR EMPLOYER _____ EMPLOYER'S INSURANCE CO. _____ POLICY OR CONTRACT NUMBER _____			
PRESCRIBED BY: <input type="checkbox"/> OPHTHALMOLOGIST <input type="checkbox"/> OPTOMETRIST <input type="checkbox"/> PHYSICIAN DATE OF PURCHASE: _____ / _____ / _____ DAY MONTH YEAR AMOUNT BILLED: \$ _____							
EYE EXAMINATIONS							
EXAM COMPLETED BY: <input type="checkbox"/> OPHTHALMOLOGIST <input type="checkbox"/> OPTOMETRIST DATE OF SERVICE: _____ / _____ / _____ DAY MONTH YEAR AMOUNT BILLED: \$ _____							
ASSIGNMENT OF BENEFITS				IF CLAIMANT IS A DEPENDENT CHILD OVER THE AGE OF 18 PLEASE COMPLETE THE FOLLOWING:			
IS PAYMENT TO BE MADE TO THE PROVIDER OF SERVICE? <input type="checkbox"/> YES <input type="checkbox"/> NO I HEREBY ASSIGN BENEFITS TO THE FOLLOWING PROVIDER: NAME _____ ADDRESS _____ _____ POSTAL CODE _____ I UNDERSTAND THAT THE CHARGES LISTED MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE ABOVE PROVIDER FOR THE COST OF TREATMENT. EMPLOYEE SIGNATURE _____				1. AGE OF CHILD _____ 2. IS HE/SHE UNMARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO 3. IS HE/SHE EMPLOYED FULL-TIME? <input type="checkbox"/> YES <input type="checkbox"/> NO IS HE/SHE IN FULL-TIME ATTENDANCE AT SCHOOL COLLEGE, OR UNIVERSITY? <input type="checkbox"/> YES <input type="checkbox"/> NO IS HE/SHE PHYSICALLY OR MENTALLY INCAPACITATED AND DEPENDENT ON YOU FOR SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
I CERTIFY THAT I AM AWARE OF AND HAVE READ THE AUTHORIZATION AND CONSENT ON THE REVERSE SIDE OF THIS CLAIM FORM. I AGREE THAT THIS CLAIM IS TRUE AND CORRECT AND AGREE THAT IT SHALL BE SUBJECT TO THE PROVISIONS OF THE POLICY.							
SIGNATURE OF INSURED _____				DATE _____			
TO BE COMPLETED BY SUPPLIER AT PLACE OF PURCHASE:							
PRESCRIPTION DETAILS, OR ATTACHED COPY OF PRESCRIPTION:				ARE THESE CORRECTIVE LENSES? <input type="checkbox"/> YES <input type="checkbox"/> NO			
SPHERE: R _____ L _____ CYLINDER: R _____ L _____ AXIS: R _____ L _____ PRISM 1: R _____ L _____ BASE 1: R _____ L _____ PRISM 2: R _____ L _____ BASE 2: R _____ L _____ ADD: R _____ L _____				IS THIS A PRESCRIPTION CHANGE? <input type="checkbox"/> YES <input type="checkbox"/> NO COST: LENSES \$ _____ FRAMES \$ _____ REPAIRS \$ _____ TINTS/COATINGS \$ _____ CONTACT LENSES \$ _____ TOTAL COST \$ _____			
<input type="checkbox"/> Non-Status <input type="checkbox"/> Status If "Status", complete the following: Total Amount of Claim: \$ _____ If the amount paid by NIHB is nil, please indicate why _____ Less any reimbursement through NIHB: \$ _____ <input type="checkbox"/> Reached annual limit Balance owing: \$ _____ <input type="checkbox"/> Other, please provide details _____							
DATE _____				I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE ARE CORRECT AND REPRESENT THOSE RENDERED TO THE PATIENT NAMED.			
				SUPPLIER'S SIGNATURE: _____			

AUTHORIZATION AND CONSENT

I understand that the personal information provided herein as well as any other personal information currently held by Rice Financial Group Inc. and the insurance carriers of my group insurance policy may be collected, used, or disclosed to administer the terms of the group policy of which I am an eligible member, to develop and recommend suitable products and services to me and my employer, and to manage the organization's business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include the insurance carriers of my group insurance policy, licensed physicians and/or any other health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in the group policy of which I am eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be declined or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

For additional information regarding Rice Financial Group Inc.'s Group Benefits privacy policy I can contact Rice Financial at 204-786-0324 or privacy@ricefinancial.com should I have questions as to the collection, use or disclosure of my personal information.