

VISION CARE CLAIM FORM



Please Return Completed Claims To:
CINUP
 491 Portage Avenue
 Winnipeg, MB R3B 2E4
 Phone: 1-800-665-1234
 Fax: 1-877-786-3889

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.
- RECEIPTS WILL NOT BE RETURNED - PLEASE KEEP COPIES FOR YOUR RECORDS. LEGIBLE PHOTOCOPIES MAY BE SUBMITTED IN PLACE OF ORIGINALS.

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|--|--|--------|--|--|--|-----------------------------------|--|
| TO BE COMPLETED BY EMPLOYEE: | | | | (PLEASE PRINT CLEARLY) | | | |
| CERTIFICATE NO. 110 | | 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 YES, COMPLETE THE FOLLOWING: CONTRACT HOLDER OF OTHER PLAN _____ BIRTHDATE _____ / _____ / _____ DAY MONTH YEAR EMPLOYER _____ EMPLOYER'S INSURANCE CO. _____ POLICY OR CONTRACT NUMBER _____ IF BLUE CROSS IS SECOND INSURER PLEASE ATTACH A STATEMENT OF PAYMENT OR DENIAL FROM FIRST INSURER AND COPIES OF THE RECEIPTS. | | | |
| 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: \$ _____ | | | | | | | |
| LASER EYE SURGERY | | | | | | | |
| 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: PROVIDER NUMBER _____ 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 MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE OF MARRIAGE DD MM YY 3. IS HE/SHE EMPLOYED FULL-TIME? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE FULL TIME EMPLOYMENT STARTED DD MM YY 4. IS HE/SHE IN FULL-TIME ATTENDANCE AT SCHOOL COLLEGE, OR UNIVERSITY? <input type="checkbox"/> YES <input type="checkbox"/> NO 5. 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 _____ | | | |
| FOR GLASSES OR CONTACT LENSES, ATTACH PRESCRIPTION OR HAVE SUPPLIER COMPLETE AT PLACE OF PURCHASE: | | | | | | | |
| PRESCRIPTION DETAILS: 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 _____ | | | | ARE THESE CORRECTIVE LENSES? <input type="checkbox"/> YES <input type="checkbox"/> NO 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 MGI Financial 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 MGI Financial Inc.'s Group Benefits privacy policy I can contact MGI Financial at 204-786-0324 or privacy@mgiwealth.com should I have questions as to the collection, use or disclosure of my personal information.