

MAIL ALL CLAIMS TO: LOCAL 183 TRUST ADMINISTRATION
1263 WILSON AVENUE, SUITE 205
NORTH YORK, ONTARIO M3M 3G2
CLAIM ENQUIRIES: 416.240.7487

**PLEASE ATTACH
THE PAID RECEIPT**

To be completed by member

Employer		Employer location (city and prov.)		
Member's Name		Policy No.	Identification No.	Date of Birth Mo. Day Yr.
Member's Address No. and Street City Prov. Postal Code				Telephone No.
If Dependant Claim, Name of Dependant		Relationship	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth Mo. Day Yr.
DO YOU HAVE ANY OTHER VISION CARE COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, PLEASE COMPLETE:				
INSURER'S NAME		GROUP NO.	POLICY NO.	EMPLOYER'S NAME
IF YES, AND CLAIM IS FOR A DEPENDENT CHILD, PLEASE INDICATE SPOUSE'S DATE OF BIRTH _____				
<input type="checkbox"/> Initial Claim	Date _____ Signature of Member _____			
<input type="checkbox"/> Subsequent Claim				

TO BE COMPLETED BY SUPPLIER

Prescribed by Ophthalmologist Optometrist **Is this a change in prescription?** Yes No

Prescription Details

	Sphere	Cylinder	Axis	Prism	Base	P.D.	Seg Height	Frame and Colour		
R						FAR		Eye Size	DBL	Temple
L						NEAR				
A D D		Tint (Specify Colour & No.)		Type of Bifocal	Type of Trifocal		Manufacturer of Supplier			
	R									
	L		1 2							

Plastic Heat Hardened Chemically Hardened

For additional information re complications ect.

Breakdown of extra charges: (e.g. oversize, photogrey, case, ect.)
Miscellaneous:

1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
4. _____	\$ _____
Total _____	

Transfer items to misc. below Amount:

Supplier Day Month Year

Date of service _____

Name _____

Address _____

City/Town _____ Prov. _____ Telephone No. _____

Postal Code

Optometrist Optician

Charges

Frames _____

Lenses _____

Fee _____

Misc. 1. _____

Misc. 2. _____

Misc. 3. _____

Total _____

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life, located within or outside Canada, to exchange personal information when necessary for these purposes. I authorize the use of my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the plan. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge.

Plan Member's Signature _____ Date _____

YOUR CLAIM CANNOT BE PROCESSED UNLESS ALL QUESTIONS ARE ANSWERED IN FULL