FORM 08
Change to Visual Acuity Form

Please attach to ***Form 07 - Extended Health Care Claim Form***.

AFBS: 1000 Yonge Street
Toronto, ON M4W 2K2
PHONE: 416-967-6600 1-800-387-8897
FAX: 416-967-4744 1-888-804-8929
EMAIL: info@afbs.ca

AFBS WEST: 300 - 380 2nd Avenue West
Vancouver, BC V5Y 1C8
PHONE: 604-801-6550 1-866-801-6550
FAX: 604-801-6580
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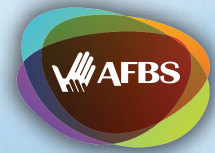

The Vision Care benefit provides reimbursement for the cost of prescription glasses or contact lenses up to a maximum every two Benefit Years. See your insurance program details for the percentage of reimbursement and maximum levels. Actra Fraternal Benefit Society (AFBS) recognizes the impact a significant change in your visual acuity can have on your life. If you or an insured dependant have a significant change in visual acuity that requires a new prescription, you may be eligible for an additional reimbursement regardless of whether a Vision Care expense has been claimed in the previous Benefit Year. THIS IS NOT A CLAIM FORM.

SECTION 1 – Member Information *(please print)*

Member Name (Last, First, Middle Initial)	Date of Birth	Telephone Number

Your Account Number	ACTRA/WGC Number (if applicable)
4501 ☐ ☐ ☐ ☐ ☐ ☐	

I participate in the following program (check one)

☐ Members' Insurance Program ☐ Employer Benefits Program ☐ Writers' Coalition Program ☐ Arts & Entertainment Plan®

☐ Other ______________________________

SECTION 2 – Please have your Optometrist or Opthamologist complete the following information.

Patient Name (Last, First, Middle Initial)

Doctor's Name	Office Telephone Number	Or, Office Stamp Here
Office Street Address		
City / Province / Postal Code		

I understand that my patient may be eligible for reimbursement of some Vision Care costs under the AFBS Extended Health Care program and I confirm that there has been a significant change in visual acuity that warrants a new glasses/contact lens prescription.

Doctor's Signature (required)	Date

SECTION 3 - Member Authorization

I certify that the glasses/contact lenses purchased on the receipt accompanying my completed Form 07 contain the lens(es) prescription change confirmed above. I further certify that none of the reimbursement requested relates to the purchase of sunglasses.

Member's Signature (required)	Date

Note: The Benefit Year reimbursement is based on the date the receipt was issued. A receipt cannot be reimbursed over two Benefit Years. However, if in the second year an additional cost was incurred as a result of a change in visual acuity, a subsequent reimbursement may be made.

AFBS is committed to protecting the confidentiality of the personal information we collect from you and will use this information to assess your claim and administer the benefit plan.

Include this form with your completed *Form 07: Extended Health Care Claim Form*, along with your receipt.

Underwritten by:
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