Manulife

Group Benefits
Vision Claim

To make a claim, original receipts (not photocopies) must accompany this claim form.
Please keep a copy of your receipt(s) for your records, originals will not be returned.

1 Plan member information

To be completed by the plan member.

Plan contract number	Plan sponsor	Plan member certificate number
1472	Health Association Nova Scotia	

Plan member name (first, middle initial, last)	Date of birth (dd/mmm/yyyy)

Plan member address (number, street and apt.)	City or town	Province	Postal code

Are you, your spouse or dependants covered under any other plan for the expenses being claimed?

◯ Yes ◯ No

If *yes*, please retain photocopies of all receipts submitted with this claim for submission to your secondary carrier. If this is your first claim, or if information has changed, please provide the following:

Spouse's date of birth (dd/mmm/yyyy)	Name of spouse's insurance company	Spouse's plan contract number	Spouse's plan member certificate number

Sign up for direct deposit and electronic claim statements

Receive your claim payments up to 70% faster with direct deposit and enjoy the convenience of seeing your claim statements online.

- Go to **www.manulife.ca/groupbenefits** and register for the plan member secure site
- Once you've registered, or if you're already registered, log into the secure site and select **Direct deposit for claims** from the menu to the left of the screen
- Enter your banking information

2 Provider statement

To be completed by provider.

Provider name	Provider number

Address (number, street, suite)	City	Province	Postal code

Telephone number	Fax number
( )	( )

Is this a new patient? ◯ Yes ◯ No	Patient name	Date of birth (dd/mmm/yyyy)

Is this eye exam required due to a medical condition/disease?

◯ Yes ◯ No If *yes*, state condition/disease

Are lenses required due to a medical condition/disease?

◯ Yes ◯ No If *yes*, state condition/disease

Benefit description		**Date of service** (dd/mmm/yyyy) *(date goods paid in full)*	**Charge** *(must be broken down by benefit description)*
Eye Examination Specify type:			
Frame			
Lens	Right		
	Left		
Tinting			
UV Coating			
Anti-reflection Coating			
Plano Sunglasses			
Contact Lens	Right		
	Left		
Other Description:			
		TOTAL	**$**

2 Provider statement *(continued)*

Note: this information is not required if this is a new patient.

Details of this prescription

	SPHERE	CYLINDER	AXIS	PRISM	BASE
Right					
Left					
ADD R					
ADD L					

Bifocal type: ◯ Round ◯ ST

Type of **right** lens

◯ Single ◯ Bifocal
◯ Multifocal ◯ Progressive
◯ Spherical ◯ Compound
◯ Hi index ◯ Polycarbonate
◯ Aspherical ◯ Slaboff

If changed, details of last prescription

	SPHERE	CYLINDER	AXIS	PRISM	BASE
Right					
Left					
ADD R					
ADD L					

Bifocal type: ◯ Round ◯ ST

Type of **left** lens

◯ Single ◯ Bifocal
◯ Multifocal ◯ Progressive
◯ Spherical ◯ Compound
◯ Hi index ◯ Polycarbonate
◯ Aspherical ◯ Slaboff

Was a change in prescription required? ◯ Yes ◯ No

Signature of provider | Date signed (dd/mmm/yyyy)

3 Claims confirmation

NOTE - ORIGINAL RECEIPTS must be attached for all expenses.

Total amount of ALL receipts submitted **$**

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. **I authorize** Manulife Financial ("Manulife") to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). **I am authorized** by my Dependants to disclose and receive their Information, for the Purposes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency,and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid. **I understand** that Manulife's Privacy Policy and Privacy Information Package are available at **www.manulife.ca/planmember**, or from my Plan Sponsor.

Please sign here

Signature of plan member | Date signed (dd/mmm/yyyy)

Any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits health file. Access to your Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- persons to whom you have granted access; and
- persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

4 Mailing instructions

Please mail your completed claim form and receipts to the appropriate address.

If you live outside Quebec:
Manulife Financial Group Benefits
Group Claims Department
PO BOX 1653
WATERLOO ON N2J 4W1

If you live in Quebec:
Manulife Financial Group Benefits
Group Claims Department
PO BOX 2580 STN B
MONTREAL QC H3B 5C6