



# VISION - Direct Reimbursement Form

## Section I – To Be Completed By Plan Member

Policy Number: 6012

Plan Member – Last Name      First Name and Initial      I.D. #

Address      City      Province      Postal Code      Telephone Number

Birthdate (dd/mm/yy)      Gender  Male  Female

### If claim is on behalf of an eligible Dependent, please complete the following:

Dependent's – Last Name      First Name and Initial      Date of Birth (dd/mm/yy)

Relationship (i.e. spouse, daughter, son)

### Co-insurance Information

Do you or your dependents have any other coverage which may pay a benefit for any of the expenses being claimed on this form?     No     Yes    If yes, please provide:

Plan Member – Last Name      First Name and Initial      Date of Birth (dd/mm/yy)

Insurance Company      Address/City/Province      Postal Code      Telephone Number      Policy Number

Are you claiming any expense resulting from injuries or illness for which benefits are payable in accordance with the provisions of any Workers' Compensation or similar law?     No     Yes

### Assignment of Benefits

If payment is to be made directly to the Plan Member:

I understand that the charges listed in this claim may not be covered by or may exceed my agreement benefits. I understand that I am financially responsible to my supplier for the cost of those services. I authorize release of the information contained in this claim form to the Insurer/Board of Trustees, its authorized representative or consultant for purposes of settlement of this claim.

\_\_\_\_\_  
Signature of Plan Member

\_\_\_\_\_  
Date

If payment is to be made directly to the Supplier:

I hereby assign my benefits payable from this claim to the supplier named on the reverse side of this claim and authorize payment directly to him/her.

Do not sign below if you do not wish the Insurer/Plan Administrator to pay the supplier direct.

\_\_\_\_\_  
Signature of Plan Member

\_\_\_\_\_  
Date

