IUPAT District Council 38 Health & Welfare Trust Fund

~ Vision Care Claim Form ~

Mail: **7621 Kingsway, Burnaby, BC V3N 3C7** | Ph: 604-524-8334 | Toll Free: 1-800-266-1527

Use this form to submit a vision care claim for eyeglasses, contact lenses, and eye exams (members only). Please enclose all supporting documentation and original receipts, and complete all parts of this form to avoid delays in processing your claim. See page 2 for important information about preparing your claim.

1. MEMBER INFORMATION

Member's DC38 ID Number	Member's Full Name	Daytime Phone Number

Member's Address/City/Street/Province/Postal Code	New Address?
	☐ Yes

2. OTHER INSURANCE COVERAGE

☆ Complete this section if you or your spouse are covered under another plan. Please see special instructions for coordination of benefits on page 2.

Name of Other Insurer	Policy Number	ID Number

3. INFORMATION ABOUT YOUR CLAIM

☆ Remember to enclose all supporting documentation and original receipts. You can mail your claim or drop it off at our **Burnaby office**.

Please provide the first name, ID, and birth date of all eligible dependents with a claim. For each dependent, add up all receipts and provide the total amount of their expenses.

First Name	ID	Birthdate	Total Expenses
		(mm-dd-yyyy)	$
		(mm-dd-yyyy)	$
		(mm-dd-yyyy)	$
		(mm-dd-yyyy)	$
		Grand Total	$

4. MEMBER CONSENT AND DECLARATION

☆ **IMPORTANT: This section must be signed before submitting your claim.**

I declare that all information in this form is true and complete. I understand that the District Council 38 Health & Welfare Trust Fund will use the personal information on this form, and any other personal information they hold about me and my eligible dependents to determine eligibility for benefits and pay claims. I acknowledge and agree that personal information about me and my eligible dependents may be collected, used, and exchanged between District Council 38 and any other person or organization related to this claim or the administration of my benefit plan. This includes health care professionals, institutions, investigative agencies, insurers/re-insurers, government organizations or regulatory bodies.

I understand I may revoke this consent at any time and acknowledge that should I do so, this claim may not be considered.

If there is overpayment, I authorize its recovery from any amount payable to me under my benefit plan(s).

I have read and understand this Member Consent and Declaration and agree that a photocopy or digital version shall be as valid as the original and may remain in effect for the continued administration of this plan.

Member's Signature	Date (mm-dd-yyyy)

IMPORTANT CLAIMING INFORMATION

Incomplete claims may cause delays in processing.

Benefit Levels

Members: up to $475.00 per 24-month period can be reimbursed for routine eye examinations, the purchase of corrective lenses and frames and/or corrective contact lenses.

Dependents: up to $300.00 per 24-month period can be reimbursed for the purchase of corrective lenses and frames and/or corrective contact lenses. (Eye examinations are NOT covered for dependents).

Note: The 24 month period begins on the date of purchase; it is not based on the calendar year. If you are unsure of your coverage period, please call us at 604-524-8334.

General Information

Please read these instructions before submitting your claim.

1. Ensure you have completed all sections.
2. Refer to your Pacific Blue Cross ID card for your ID and dependent numbers.
3. All claims must be submitted with ITEMIZED ORIGINAL PAID RECEIPT(S) and must include:
    - Claimant's first and last name
    - Description of item purchased or service rendered
    - Date of each purchase or service
    - Amount charged for each purchase or service
    - Name, address and telephone number of supplier or provider
4. Claims for eligible Vision Care expenses incurred in a given year must be post-marked prior to June 30 of the following year to be eligible for reimbursement.
5. The claim form along with all receipts will be returned to you. (See Member's Consent).
6. Please do not staple the form or receipts.
7. Ensure that section 4 has been read and signed.

Other Coverage / Coordination of Benefits

1. If you are claiming expenses for your spouse and your spouse is covered under another health benefit plan, you must submit the claim to your spouse's plan first.
2. If both you and your spouse have Vision Care benefit coverage, your children must claim under the plan of the parent with the earliest birthday (month and day) in the calendar year. (For example: if your birthday is May 1 and your spouse's is June 5, your children will claim under your plan first).
3. If you have submitted your original receipt to your other insurance company, please provide the following:
    - Photocopies of all invoices and paid-in full receipts
    - The original statement from the other insurance company showing payment or denial of your claim.

Mailing Address

IUPAT DC38 Health & Welfare
7621 Kingsway
Burnaby, BC V3N 3C7

NOTE: Claim forms cannot be submitted online or by fax and must be dropped off or mailed to the address above.