

## **Group Benefits Vision Care Claim Form**

## PLAN MEMBER INFORMATION

Vision Care	5 Ciaiiii i C			TEAN MEMBER INFORMATION								
SUBMIT CLAIM TO:				PLAN CONTRACT NUMBER  PLAN MEMBER CERTIFICATE NUMBER  PLAN SPONSOR NAME								
	PO BOX 400, WAT											
Web Site: www.manulife.ca/groupbenefits/secureserve						PLAN MEMBER'S LAST NAME FIRST NAME						
PATIENT INFORMATION						ADDRESS APT.						
SURNAME GIVEN NAME						CITY	PROVINCE POSTAL CODE					
RELATIONSHIP TO PLAN MEMBER						DO YOU HAVE ANY OTHER VISION CARE COVERAGE?   YES   NO						
DATE OF BIRTH (D/M/Y	7)					IF YES, PLEAS	SE COMPLETE					
( ) TELEPHONE						PLAN SPONSOF	R'S NAME PLAN CON	TRACT NO.	PLAN MEM	BER CERTIFICATE NO.		
To Be Comple	eted by Disne	enser		PR	ESCRIPT	TION DETAIL	LS					
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If claim for conta		. 1 20	/70 : 41	1			2.		- <del>\$</del> \$	<u> </u>		
with conventio	ity be restored to at onal eye glasses?			l Yes	re □ No		3.		- <del>\$</del> \$			
b) Are they medically necessary due to keratoconus, irregular astigmatism or irregular corneal curvature?							4.		Total \$			
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