

**MOUNT SAINT VINCENT UNIVERSITY STUDENTS' UNION
MEMBERS OF THE CAMPUS TRUST VISION CARE PLAN
STATEMENT OF CLAIM**

TO BE COMPLETED BY STUDENT:

YOUR CLAIM CANNOT BE PROCESSED UNLESS ALL QUESTIONS HAVE BEEN ANSWERED IN FULL AND ALL RECEIPTS ARE ATTACHED

STUDENT NAME: _____ **STUDENT I.D.:** _____ **D.O.B.** ____ / ____ / ____
MM DD YY

STUDENT ADDRESS: _____
NO. AND STREET CITY

PROVINCE POSTAL CODE TELEPHONE NUMBER

If Dependent Claim, Name of Dependent: _____ **Relationship:** _____

D.O.B.: ____ / ____ / ____ **SEX:** MALE FEMALE
MM DD YY

TO BE COMPLETED BY SUPPLIER:

Practitioner Name: _____ **City/Province:** _____

Telephone: _____ **Date of Service:** _____

PATIENT PRESCRIPTION

	SPHERE	CYLINDER	AXIS
R			
L			

PRODUCT INFORMATION

LENSES: Plastic Glass SV Bifocal Trifocal Progressive

Brand Name _____ Lens Type _____
Name of Laboratory _____ Invoice # _____

FRAME: Supplier _____ Model # _____
Colour _____ Invoice # _____
Size _____

CONTACT LENSES: NEW REPLACEMENT Invoice # _____

	Sphere	Cyl/Axis	BC	Diam	Lens Type	Colour	Supplier
R							
L							

CHARGES: Frame _____
Lenses _____
Exam Fee _____
Contacts _____
Misc. _____
TOTAL: \$ _____

Y N

I have received an eye examination _____ **Initials** _____

I have received eyewear and /or contact lenses _____

I authorize the release of any information or records requested in respect of this claim and certify that the information I have given on this form is true, correct and complete to the best of my knowledge.

Signature

Date Signed

For Vision Reimbursement, complete required parts and send with receipts to:
**Plan Administrator: 1st Floor, Beothuk Building, 20 Crosbie Place
 St. John's, Newfoundland A1B 3Y8
 Tel: (709) 754-6633 or 1 (800) 563-1930
 Fax: (709) 754-6733**