Electrical Industry Insurance Benefit Trust Fund of Alberta
4211 – 95 Street NW, Edmonton, Alberta T6E 5R6
Phone: (780) 465-2882 Toll Free 1-800-268-3649
Fax: (780) 465-0808 Email: claims@ebfa.ca

VISION - Direct Reimbursement Form

Section I – To Be Completed By Plan Member

Policy Number: **6012**

Plan Member – Last Name, First Name and Initial: EBFA Stakeholder Number:

Address: City: Province: Postal Code: Telephone Number:

Cell Number: Birth date (dd/mm/yy): Gender: ☐ Male ☐ Female

Claimant Information:

Patient Name:	Date of Birth (dd/mm/yy):	Relationship to Plan Member:

Coordination of Benefits:

Do you or your dependents have any other coverage for the expenses being claimed on this form?
□ **Yes** □ **No** **If yes, please provide:**

Name of Insured: _____ Name of Insurance Company: _____

Date of birth (dd/mm/yy): _____ Plan Policy Number: _____

Plan Member ID Number: _____ Plan Effective Date: _____

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? □ Yes □ No

Documents To Be Provided With This Claim:

- A paid receipt which includes the breakdown of charges or an invoice including the breakdown of charges
- A copy of the prescription details from the eye examiner
- A co-insurance statement of payment or denial (if applicable)

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 benefits. I understand that I am financially responsible to my supplier for the cost of these services.

I certify the charges for the vision expenses which are listed herein and for which the receipt(s) are attached were incurred by myself, on account of myself, or one of my eligible dependents.

I hereby authorize the release of information contained in, or pertaining to this claim to the insurer, Plan Administrator, Medical Consultant, Trustees or any of their authorized representatives for purposes of settlement of this claim.

_____
Signature of Plan Member

_____
Date (dd/mm/yy)

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 invoice and authorize payment directly to the supplier. I authorize the release of information contained in, or pertaining to this claim to the insurer, Plan Administrator, Medical Consultant, Trustees or any of their authorized representatives for purposes of settlement of this claim.

I certify the charges for the vision expenses which are listed herein and for which the invoice is attached were incurred by myself on account of myself or one of my eligible dependents. I understand that the charges listed in this claim may not be covered by or may exceed my benefits. I understand that I am financially responsible to my supplier for the cost of these services.

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

_____
Signature of Plan Member

_____
Date (dd/mm/yy)