Electrical Workers' Health & Welfare Fund ALBERTA

Electrical Industry Insurance Benefit Trust Fund of Alberta
#200, 4224 – 93 Street, Edmonton, Alberta T6E 5P5
Phone: (780) 465-2882 Toll Free 1-800-268-3649
Facsimile: (780) 465-0808
e-mail: 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:

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

If This 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? □ Yes □ No 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? □ Yes □ No

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 (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 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 (dd/mm/yy)

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Vision Care Statement – Direct Reimbursement

Privacy Issues

I certify the charges for the medical supplies which are listed herein and for which the bills are attached were incurred by myself on account of myself or one of my eligible family members.

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)

Part 2 – To Be Completed By The Supplier

Patient's Name:		Sphere	Cylinder	Axis	Prism	Base	P.D.	Seg. Height
	R						Far	
	L						Near	

Date of Birth (dd/mm/yyyy):			Tint (Specify Colour & No.)	Type of Bifocal	Type of Trifocal
	ADD	R			
	ADD	L	1 2		

☐ Plastic ☐ Heat Hardened ☐ Chemically Hardened

Prescribed By: ☐ Opthalmologist ☐ Optometrist

Is this a prescription Change? ☐ Yes ☐ No

DATE OF SERVICE _____
(dd/mm/yy)

Supplier:

_____
Name

_____
Address

_____
City, Province, Postal Code

_____
Telephone Number

_____
Signature

Breakdown Of Charges:

1. EYE EXAM $ _____
2. LENSES $ _____
3. FRAME $_____
4. CONTACTS $_____

Miscellaneous: (e.g. oversize, photogrey, case, clip-on, cleaners, etc.)

5. _____ $_____
6. _____ $_____
7. _____ $_____
8. _____ $_____
9. _____ $_____

TOTAL $_____