



VISION CARE * Please complete in full. Any receipts from supplier must also be submitted.

Employee's Name | Policy Number | Certificate Number

Employee's Address (street, city, province, postal code)

Name of Patient | Date of Birth | Relationship to Employee

If patient is a dependent child, please complete:
Is he/she attending school full-time?
Date schooling will be completed:
Is he/she working full-time?
Is he/she working part-time?

Name of Employer

Is patient covered through any other Group Insurance Plan which provides Optical Benefits?
date | Employee's signature

TO BE COMPLETED BY SUPPLIER

Optical Supplies were furnished by:
Name | Address

Date Glasses/Contacts Ordered

Glasses
Is this the first pair of glasses?
If "No", did prescription change?
If "Yes", did the prescription change in the

Cost of Glasses:
Laboratory Cost of Lenses
Laboratory Cost of Frames
Ophthalmic Dispensing Fee
Eye Examination
Other
TOTAL
Were lenses tinted or photo-grey?
If "Yes", please indicate the cost for this service.
Are these
a) Prescription sun glasses?
b) Replacement of lost or damaged glasses?

Contact Lenses
Is this the first pair of lenses?
If "No", did prescription change?
If "Yes", did the prescription change in the
Were contact lenses prescribed for severe corneal astigmatism, keratoconus or aphakia?
Can visual acuity be improved up to at least the 20/40 level by contact lenses?
Could visual acuity be improved up to at least the 20/40 level by glasses?

I certify that the information given on this form is true, correct and complete to the best of my knowledge. The claim information willingly provided by me to Equitable Life held in their files, will be used by Equitable Life for the purposes of claims processing and adjudication.

Date | Signature of Supplier