canada life™

VISION CARE STATEMENT OF CLAIM
LiUNAcare LOCAL 3000

MAIL ALL CLAIMS TO: LiUNAcare LOCAL 3000
90 Burnhamthorpe Road West, Suite 300
Mississauga ON L5B 3C3
P: 905-247-3040
F: 905-275-6462 • E: info@liunacare3000.com

PLEASE ATTACH THE PAID RECEIPT

Please type or print, including all information indicated. Use more than one form if necessary.

Employer	Employer location (city and prov.)		
Member's Name	Policy No. **177882**	Identification No.	Date of Birth Mo. Day Yr.
Member's Address No. and Street City Prov. Postal Code			Telephone No.
If Dependant Claim, Name of Dependant	Relationship		Date of Birth Mo. Day Yr.

DO YOU HAVE ANY OTHER VISION CARE COVERAGE? ☐ YES ☐ NO ☐ IF YES, PLEASE COMPLETE:

INSURER'S NAME ____ GROUP NO. ____ POLICY NO. ____ EMPLOYER'S NAME ____

IF YES, AND CLAIM IS FOR A DEPENDENT CHILD, PLEASE INDICATE SPOUSE'S DATE OF BIRTH ____

☐ Initial Claim
☐ Subsequent Claim

Date ____ Signature of Member ____

TO BE COMPLETED BY SUPPLIER

Prescribed by ☐ Ophthamologist ☐ Optometrist **Is this a change in prescription?** ☐ Yes ☐ No

Prescription Details

		Sphere	Cylinder	Axis	Prism	Base	P.D.	Seg Height	Frame and Colour		
R							FAR		Eye Size	DBL	Temple
L							NEAR				
ADD			Tint (Specify Colour & No.)		Type of Bifocal		Type of Trifocal		Manufacturer of Supplier		
	R										
	L		1	2							

☐ Plastic ☐ Heat Hardened ☐ Chemically Hardened

For additional information re complications ect.

____

____

Breakbown of extra charges:
(e.g. oversize, photogrey, case, ect.)

Miscellaneous:	Transfer items to misc. below Amount:
1. ____	$ ____
2. ____	$ ____
3. ____	$ ____
4. ____	$ ____
	Total ____

Supplier Day Month Year
Date of service

Name ____

Address ____

City/Town ____ Prov. ____ Telephone No. ____

Postal Code ☐☐☐ ☐☐☐

☐ Optometrist ☐ Optician

Charges	
Frames	
Lenses	
Fee	
Misc. 1.	
Misc. 2.	
Misc. 3.	
Total	

At Canada Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. I authorize Canada Life, any healthcare or dentalcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Canada Life located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to canadalife.com

Plan Member's Signature ____ Date ____

YOUR CLAIM CANNOT BE PROCESSED UNLESS ALL QUESTIONS ARE ANSWERED IN FULL

©The Canada Life Assurance Company, all rights reserved. Canada Life and design are trademarks of The Canada Life Assurance Company. Any modification of this document without the express written consent of Canada Life is strictly prohibited.