Local 213 Electrical Workers' Welfare Plan
1424 Broadway Street, Port Coquitlam BC V3C 5W2
Tel 604-571-6545 | Fax 604-571-6544 | Email:info@213benefits.org

Print more claim forms from the Plan website at www.213pension.org -> Health and Welfare -> Forms and Resources Library

OPTICAL SERVICES CLAIM FORM

Plan Member's Full Name: _____

MEMBER to complete Parts 1, 3, 5 and sign and date bottom of form, PROVIDER to complete parts 2, 4 and sign Declaration (Required) in Part 4

Pacific Blue Cross ID # (leave blank if not known):

Date of Birth (Day/Month/Year): / /

PART 1: PLAN MEMBER'S CONTACT INFORMATION

Street_____

City/Postal Code_____

Phone Number_____

PART 2: VISION PROVIDER INFORMATION

Name_____

Address/City_____

Clinic Name _____

College Optician #_____

Phone Number_____

PART 3: COMPLETE THIS SECTION IF THIS CLAIM IS FOR YOUR DEPENDENTS

Dependent's name (Last, First)	Date of Birth Day	Month	Year	Relationship to Plan Member
				☐ Spouse ☐ Child ☐ Other_____

OTHER COVERAGE: Does your Dependent above have coverage for this expense under another benefits plan? If Yes, attach copies of the Explanation of Benefits or Claim Statement from the other Plan to show proof of Reimbursement amount. ☐ Yes ☐ No

PART 4: NOT REQUIRED FOR ONLINE PURCHASES - DETAILS OF THE PRESCRIPTION (PROVIDER TO COMPLETE and SIGN REQUIRED DECLARATION)

		Sphere	Cylinder	Axis	Prism	Add
New Rx ☐	Right					
	Left					
Old Rx ☐	Right					
	Left					

Instead of the above section, a printout of the official Optical prescription from the supplier can be provided and attached to this completed form. Signed **Declaration and Type of Expense are required**.

NOT REQUIRED FOR ONLINE PURCHASES

PROVIDER DECLARATION: I hereby certify that I have rendered the goods and / or services to the claimant named as detailed.

SIGNATURE OF PROVIDER_____DATE _____

TYPE OF EXPENSE: (*must* be checked)

☐ eye examination ☐ prescription sunglasses*

☐ prescription glasses ☐ prescription safety glasses*

☐ contact lenses ☐ lenses only*

☐ laser eye surgery

☐ cataract surgery (non-MSP covered)

☐ other: (indicate any medical conditions or disease)

_____

*Prescriptions for glasses/lenses must not be dated less than 24 months from the date of purchase for reimbursement under the Welfare Plan.

PART 5: VISION EXPENSES (Attach original paid in full receipts and list below)

Nature of expense	Date incurred Day/Month/Year	Amount

Total = $ 0.00

I hereby certify that the above listed expenses were incurred by myself or my dependents, on the dates shown and that the information and amounts are correct. I understand that the Local 213 Electrical Workers' Welfare Plan is a reimbursement plan and I am not submitting for any amounts I have not paid for in full. I hereby authorize the Plan Administrator to use the information provided by me on this form to administer my benefits under the Welfare Plan.

Plan Member's Signature_____ Date_____

UNLESS THIS IS AN ONLINE PURCHASE, YOUR PROVIDER MUST INDICATE THE TYPE OF EXPENSE AND SIGN THE DECLARATION IN PART 4 OR THE FORM IS INCOMPLETE.