

SHEET METAL WORKERS (LOCAL 280) HEALTH BENEFIT PLAN

6192 Kingsway, Burnaby, BC V5J 1H5
Phone (604) 430-3015 toll free 1-888-892-1168

VISION CARE CLAIM FORM / REIMBURSEMENT STATEMENT

Member Name _____ Group Number _____ Identity Number _____

Address _____ City/Province _____ Postal Code _____ Area Code / Phone Number _____

EXPENSE INFORMATION – Please include ORIGINAL paid receipts (which will be returned) –

| Name of claimant <i>ONE CLAIM FORM PER PERSON</i> | Dependent Number | Type of Expense (see over for online/out of province purchases) | Date of Purchase/Service | Amount Paid |
|--|---------------------|---|-----------------------------|-------------|
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Do you or any of the dependents you are claiming reimbursement for have any vision care coverage other than provided by this Plan? Y _____ N _____

Name of other insurance carrier _____ Group Number _____ ID Number of person insured _____

If another insurance carrier is the first payer of this claim, enclose their explanation of benefits, remittance stub or statement.

Dependent children are always covered primarily under the parent who has the earliest birth date in the year (month and day) ****SEE OVER**

Total reimbursement shall never exceed 100% of the eligible expense

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 Sheet Metal Workers (Local 280) Health Benefit 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 HEALTH BENEFIT PLAN AND THE PENSION PLAN. I FURTHER CONSENT TO THE RELEASE OF THIS INFORMATION TO MY INSURER(S), IF APPLICABLE AND REQUIRED BY MY INSURER(S), AND TO MY LOCAL UNION OFFICE, IF REQUIRED.

Member's Signature _____

Date _____

THIS SECTION FOR OFFICE USE ONLY

YOUR GLASSES/CONTACTS ANNIVERSARY PERIOD IS FROM

[A] (MM/YY) _____ TO [B] (MM/YY) _____

YOUR EYE EXAM ANNIVERSARY PERIOD IS FROM

[A] (MM/YY) _____ TO [B] (MM/YY) _____

REIMBURSEMENT DESCRIPTION

| ITEM | Paid since last anniversary [a] above | Total Amount Submitted | Less Other Carrier Reimburse- ment | Total Claim at 90% | Eligible Amount Paid | Amount remaining until next anniversary [b] above |
|-------------------------------------|--|------------------------------|---|-----------------------|-------------------------|---|
| GLASSES/CONTACTS (90% MAX \$400) | | | | | | |
| EYE EXAM (100% MAX \$75) | | | | | | |
| TOTAL: | | | | | | |

Vision Care Policy

Reimbursement for Prescription Eyeglasses, Contact Lenses and Corrective Laser Eye Surgery will be processed by the Sheet Metal Workers (L 280) Benefits Administration Office. The allowable reimbursement for each member or dependent covered at the time of purchase is 90% of eligible expenses to a maximum of \$400.00.

1. Reimbursement will only be made upon completion of the Vision Care claim form and submission of original receipt(s). All receipts will be returned to the member.
2. Reimbursement for Corrective Laser Eye Surgery will be accepted with eligible original receipts dated after January 1st 2005. This Plan is not endorsing the surgical procedure and does not assume responsibility for any problems arising there from.
3. Effective April 1, 2009 receipts for Eye Examinations will be eligible for reimbursement up to \$75.00 every 24 months. This benefit will be reset every 24 months, and you may **not** hold receipts to submit on your next anniversary date.
4. As of Jan 1/05, the start date of a 24 month period for a covered member or dependent shall be determined by his or her most recent past purchase date of eligible Vision Care. If no past purchase exists within the last 24 months [from Jan 1/05], the purchase date of the current submission will set the start day of the covered member's or dependent's reimbursement anniversary. This anniversary date will remain constant for the life of the member or dependent coverage. **You must be covered at both the purchase AND submission dates (eligible purchases submitted within 30 days of coverage cancellation will be covered).**
5. As of January 1st 2005 eligible Vision Care receipts can be submitted up to a maximum 24 months from the purchase date, with the exception of Eye Examination receipts.
6. If the reimbursement limit has been reached in a 24 month period, new eligible purchases made during that period can be carried forward to the next period (with the exception of Eye Examinations). **WE WILL ONLY REIMBURSE RECEIPTS ONCE; ANY UNINSURED PORTION MAY NOT BE RE-SUBMITTED AT YOUR NEXT ANNIVERSARY DATE.**
7. You may submit for **out of province or online purchases**, but you must provide **ALL of the following**:
 - a. a paid receipt;
 - b. **a packing slip** for proof of delivery **for online orders**;
 - c. a copy of your credit card statement* showing the Canadian dollar conversion can be submitted with your claim, otherwise the Bank of Canada exchange rate in effect on the purchase date will be used.

*Please remember to blank out **ALL** other credit card information, leaving only the vision care purchase and exchange rate visible.

**In situations of separation or divorce, the following order applies:

1. the plan of the parent with custody of the child;
2. the plan of the Spouse of the parent with custody of the child;
3. the plan of the parent not having custody of the child; and
4. the plan of the Spouse of the parent in 3) above.

Updated Oct 2011