

**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**

Member Name \_\_\_\_\_ Group Number \_\_\_\_\_ Social Insurance Number \_\_\_\_\_

Address \_\_\_\_\_ City/Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Area Code / Phone Number \_\_\_\_\_

**EXPENSE INFORMATION – Please include ORIGINAL paid receipts**

Name of Person Receiving Treatment	Dependent Number	Birthdate (mm/dd/yy)	Type of Expense	Date of Purchase/Service	Amount Paid

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 \_\_\_\_\_

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). 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
4. the plan of the Spouse of the parent in 3) above

**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 \_\_\_\_\_

## **Vision Care Policy**

Reimbursement for Prescription Eyeglasses, Contact Lenses and Corrective Laser Eye Surgery will be processed by the Sheet Metal Workers (L280) 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\*\* every 24 months.

1. Reimbursement will only be made upon completion of the Vision Care claim form and submission of original receipt(s). Non eligible receipts will be sent back to the member.
2. Reimbursement for Corrective Laser Eye Surgery will be accepted with eligible original receipts dated after January 1<sup>st</sup> 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 expense must be incurred **no sooner** than 24 months from your last visit, and you may **not** hold receipts to submit on your 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.
5. As of January 1<sup>st</sup> 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. **WE WILL ONLY REIMBURSE RECEIPTS ONCE; ANY UNINSURED PORTION MAY NOT BE RE-SUBMITTED AT YOUR NEXT ANNIVERSARY DATE.**

**\*\* The Vision Care benefit has increased to \$400 (from \$200) effective April 1, 2009. Purchases and/or anniversary dates prior to April 1, 2009 will be reimbursed at the previous \$200 maximum.**