VISION CLAIM FORM

PART 1. TO BE COMPLETED AND SIGNED BY THE INSURED

1. Patient's name: (first, middle initial, last)	2. Patient's Birthday (DD/MM/YY)	3. Insured's name (first, middle initial, last)
4. Patient's Full address & Tel. number	5. Patient's Sex ☐ Male ☐ Female 7. Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other	6. Is the Insured a full time student? ☐ Yes ☐ No If yes, name & address of school
8. Insured's Policy number	10. Was condition related to: A. Patient's Employment ☐ Yes ☐ No B. An Accident ☐ Yes ☐ No	11. If an accident, give date and brief details.
9. Does the patient have other vision insurance? ☐ **Yes** ☐ **No** If YES, provide name & address of insurance company, policy number and name of insured		

12. The above answers are true and complete according to the best of my knowledge and belief. I hereby authorize my doctor to furnish and disclose all facts concerning this claim.

Signature of insured/patient: **Date:**

PART II TO BE COMPLETED BY DOCTOR

Date of examination:	Refraction	
	No Refraction	

If you prescribed glasses, indicate the type:
☐ Single vision ☐ bifocal ☐ trifocal ☐ contacts

Has cataract surgery been performed? ☐ **Yes** ☐ **No** If YES, date:

Can visual activity be restored to at least 20/20 in the better eye with conventional glasses?
☐ **Yes** ☐ **No**

Is this a prescription change from last year? ☐ **Yes** ☐ **No**	Best corrected visual acuity R E 20/ LE 20/
RVS no.	Examination fee

DOCTOR'S PRESCRIPTION

	Sphere	Cylinder	Axis	Prism	Base
R E					
L E					
Reading add	R E		L E		

COMMENTS:

SIGNATURE: DATE:

X

Please type or print name of doctor

Address:

City, Country

PART III. DISPENSER TO COMPLETE

Order date	Delivery date	Glass lens	
		Plastic lens	

Right lens charge	$
Left lens charge	$
Oversize charge (if any)	$
☐ Prism charge ☐ other	$
Slab off charge _____	$
Tint charge: colour _____ No. _____	$
Frame charge Name of frame_____	$
Is frame size over 54MM? ☐ **Yes** ☐ **No**	
Contact Lens charge ☐ **Hard** ☐ **Soft**	$
TOTAL for optical materials	**$**

COMMENTS:

SIGNATURE: DATE:

X

Please type or print name of doctor

Address:

City, Country