



# Vision Care Claim Form

## PART 1 EMPLOYEE/MEMBER/PATIENT INFORMATION

Employee Name	Employee ID	Date of Birth
Mailing Address	Email Address	
City	Province	Postal Code
Patient's Name	Relationship to Employee	Patient's Date of Birth

## PART 2 COORDINATION OF BENEFITS

Are you or your spouse entitled to vision benefits under any other plan? Yes  No   
If yes, is the plan a: Group Policy  Individual Policy   
Does this plan cover eye exams? Yes  No

Name of Insurer	Policy Number
Name of Spouse	Date of Birth

## PART 3 DISPENSARY/SUPPLIER INFORMATION

Name of Supplier/Dispensary	Mailing Address		
City	Province	Postal Code	Phone Number
Email Address			
Number of Receipts Attached*: _____			
Total Cost of Receipts Attached: \$ _____			

**\*ORIGINAL RECEIPT(S) MUST BE ATTACHED TO THIS CLAIM FORM. PHOTOCOPIES WILL NOT BE ACCEPTED UNLESS ACCOMPANIED BY AN EXPLANATION OF BENEFITS FROM AN ALTERNATE INSURER.**

At SUMA, we recognize and respect the importance of privacy. Personal information that we collect will be used only for the purposes of assessing your claim and administering the group benefits plan.

I authorize SUMA, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with SUMA 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 certify that the information given is true, correct, and complete to the best of my knowledge.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

## PART 4 FOR OFFICE USE ONLY

			Prior Claims
Member Name	Division #	Effective Date	
Claimant Code	Dependant Status	Amount Payable	
Extended Health Care Participant?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Authorization Signature		Date	

**TO AVOID DELAYS IN PROCESSING YOUR CLAIM, PLEASE SUBMIT CLAIMS TO SUMA'S OFFICE IN A TIMELY MANNER.**

# How to Claim Vision Care Benefits

## Before completing the form:

1. If you are claiming expenses for your spouse and your spouse is covered for vision care benefits under another plan, you must submit the claim to your spouse's plan first.
2. If both you and your spouse have vision care benefits, your children must claim under the plan of the parent with the earliest birthday (month and day) in the calendar year. *For example, if your birthday is May 1 and your spouse's birthday is June 5, your children will claim under your plan first.*
3. If you have extended health benefits through SUMA or other group insurance, and your claim includes the cost of an eye exam, you must submit the claim for the eye exam to Great-West Life or your other insurer first. Any amount of the eye exam that remains unpaid by Great-West Life or your other insurer, can then be submitted to SUMA under your vision care plan.

## After completing the form:

4. Please make sure that you have filled in all of the information completed and have signed the form. Incomplete forms will delay the processing of your claim.
5. **Original** receipts for expenses must be submitted with your claim. Copies will be accepted **only** if an expense has been previously submitted under another plan and is accompanied by a copy of the Explanation of Benefits you received from the alternate insurer. SUMA will not return any original receipts; you will receive an Explanation of Benefits from SUMA for your records.
6. Mail the completed form to:

Saskatchewan Urban Municipalities Association  
Attn: Group Benefits and Insurance Services  
Unit 305 - 4741 Parliament Ave  
Regina, SK S4W 0T9

## Direct Deposit Authorization:

*Did you know that you can have your vision care benefit payments automatically deposited into your bank account by way of Electronic Funds Transfer (EFT) from SUMA?*

If you would like to take advantage of EFT payments or would like to make changes to banking information previously provided to SUMA, please complete the following information:

**Effective \_\_\_\_\_ please deposit my payments to the following account:**

Date

**PLEASE PRINT CLEARLY**

\_\_\_\_\_  
Name of Banking Institution

\_\_\_\_\_  
Transit #

\_\_\_\_\_  
Institution #

\_\_\_\_\_  
Account Number

\_\_\_\_\_  
Branch Address

\_\_\_\_\_  
City

\_\_\_\_\_  
Province

\_\_\_\_\_  
Postal Code

\_\_\_\_\_  
Name in which account is held

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

**Please attach a "VOID" cheque or a Direct Deposit Information sheet, provided to you by your bank.**

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