

Mail all correspondence to:

Saskatchewan Piping Industry Health & Welfare Trust Fund
c/o Global Benefit Plan Consultants Inc.
545 Wilson Avenue, Toronto, Ontario M3H 1V2
Phone 416-635-6000 ✉ Fax 416-635-6464



TO BE COMPLETED BY MEMBER Please print clearly.

Member's Name		Social Insurance Number	
Street Address			
City/Town		Province	Postal Code
1.	Claim submitted for: <input type="checkbox"/> MEMBER <input type="checkbox"/> DEPENDENT		
	If claim for DEPENDENT, Name of Dependent	Relationship	
		Date of Birth (dd/mm/yyyy)	
2.	Is patient covered under any other group insurance plan which provides vision care benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, give details: (Name of company, policy number, certificate, amount paid, etc.)		

TO BE COMPLETED BY THE SUPPLIER OF CORRECTIVE LENSES Please print clearly.

1. A. CHARGES FOR MATERIALS SUPPLIED	B. TYPE OF LENSES SUPPLIED	Left Eye	Right Eye	C. Visual Acuity (without lenses)
Frames \$	Plain glass			Right eye: _____
Lens for right eye \$	Single vision			
Lens for left eye \$	Bifocal			Left eye: _____
Other \$	Trifocal			
\$	Contact			
Are these security glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Give reasons for any charges under heading "Other" in question 1.A), e.g. hardening, tinting, etc				
2. TO BE COMPLETED FOR CONTACT LENSES				
1. Were contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus or aphakia?				<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Can visual acuity be improved up to at least the 20/40 level by contact lenses?				<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Can vision be corrected by standard glasses?				<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Was this client ever operated for cataract?				<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Identity of the person who recommended these correcting lenses:				
NAME		PROFESSION		
4. Supplier's Name (print) _____				<input type="checkbox"/> Ophthalmologist
Supplier's Address _____				<input type="checkbox"/> Optometrist
_____				<input type="checkbox"/> Optician
_____				<input type="checkbox"/> Other (specify)
Date of purchase: _____				

ANY CHARGE FOR COMPLETING THIS FORM IS PAYABLE BY THE MEMBER.