SASKATCHEWAN PIPING INDUSTRY
HEALTH & WELFARE TRUST FUND

Record of Expenses for Vision Care

Mail all correspondence to:

GLOBAL BENEFITS
191 THE WEST MALL, SUITE 901,
ETOBICOKE ON
M9C 5K8

GLOBAL BENEFITS

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: ☐ MEMBER ☐ 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? ☐ Yes ☐ 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
Frames	$	Plain glass		
Lens for right eye	$	Single vision		
Lens for left eye	$	Bifocal		
Other	$	Trifocal		
	$	Contact		

C. Visual Acuity (without lenses)

Right eye: _____

Left eye: _____

Are these security glasses? ☐ Yes ☐ 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? ☐ Yes ☐ No
   2. Can visual acuity be improved up to at least the 20/40 level by contact lenses? ☐ Yes ☐ No
   3. Can vision be corrected by standard glasses? ☐ Yes ☐ No
   4. Was this client ever operated for cataract? ☐ Yes ☐ No

3. Identity of the person who recommended these correcting lenses:
   NAME PROFESSION

4. Supplier's Name (print) _____
   Supplier's Address _____
   _____
   _____
   Date of purchase:

   ☐ Opthalmologist
   ☐ Optometrist
   ☐ Optician
   ☐ Other (specify)

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

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