MANITOBA BLUE CROSS®

CINUP

PRESCRIPTION INDUSTRIAL SAFETY GLASSES CLAIM FORM

READ CAREFULLY

- "PRESCRIPTION INDUSTRIAL SAFETY GLASSES" MEANS FRAMES AND LENSES THAT MEET CSA APPROVAL Z94.3 – OR EQUIVALENT TO.
- ANY EXPENSE IN EXCESS OF YOUR BENEFIT MAXIMUM WILL BE YOUR RESPONSIBILITY.
- PLEASE ATTACH ITEMIZED RECEIPTS/INVOICES AND PRESCRIPTION/REFERRALS. A COPY OF A VALID PRESCRIPTION IS REQUIRED FOR VISION CLAIMS.
- PLEASE SEND COMPLETED CLAIM FORM TO:

CINUP
332 BANNATYNE AVENUE, SUITE 500
WINNIPEG, MB
R3A 0E2

INSTRUCTIONS:

- COVERAGE IS FOR **EMPLOYEES** ONLY
- THIS FORM IS TO BE USED FOR PRESCRIPTION SAFETY GLASSES ONLY

NOTE: THE ASSIGNMENT OF BENEFITS BELOW MUST BE COMPLETED AND SIGNED.

CLAIMANT DATA

(PLEASE PRINT CLEARLY)

BLUE CROSS CERTIFICATE	CLIENT	SURNAME	GIVEN NAME AND INITIAL	DATE OF BIRTH (DAY / MONTH / YEAR)
1 0				

ADDRESS

SERVICE PROVIDER DATA

NAME OF SAFETY GLASSES: _____

MANUFACTURER OF GLASSES: _____

ARE GLASSES C.S.A. APPROVED?	☐ YES	☐ NO
ARE GLASSES A MINIMUM 3MM. IN THICKNESS?	☐ YES	☐ NO
DO GLASSES HAVE SIDE SHIELDS?	☐ YES	☐ NO
ARE LENSES PLASTIC?	☐ YES	☐ NO
ARE LENSES POLYCARBONATE?	☐ YES	☐ NO

PRESCRIBING OPTOMETRIST: _____

ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN BENEFITS TO THE FOLLOWING:

NAME OF OPTICAL COMPANY: _____

ADDRESS: _____

_____

I UNDERSTAND THAT THE CHARGES LISTED MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE ABOVE SERVICE PROVIDER FOR THE COST OF TREATMENT.

MEMBER'S SIGNATURE _____
(PLEASE SIGN HERE)

CLAIM

DATE OF PURCHASE: _____/_____/_____
DAY MONTH YEAR

AMOUNT OF CLAIM: $_____

I CERTIFY THAT I AM AWARE OF AND HAVE READ THE AUTHORIZATION AND CONSENT ON THE REVERSE SIDE OF THIS CLAIM FORM. I AGREE THAT THIS CLAIM IS TRUE AND CORRECT AND AGREE THAT IT SHALL BE SUBJECT TO THE PROVISION OF THE CONTRACT.

SIGNATURE OF MEMBER _____

DATE _____

332 Bannatyne Avenue, Suite 500, Winnipeg, MB R3A 0E2 **PHONE** 1.800.665.1234 **FAX** 1.877.786.3889

MBC 1053-2M-01/2016

AUTHORIZATION AND CONSENT

I understand that the personal information provided herein as well as any other personal information currently held by JG Benefits Inc. and the insurance carriers of my group insurance policy may be collected, used, or disclosed to administer the terms of the group policy of which I am an eligible member, to develop and recommend suitable products and services to me and my employer, and to manage the organization's business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include the insurance carriers of my group insurance policy, licensed physicians and/or any other health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in the group policy of which I am eligible member.
I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be declined or rescinded. I understand why my personal information is needed and am aware of the risks and benefits or consenting or refusing to consent to its disclosure. For additional information regarding JG Benefits Inc.'s group benefits privacy policy I can refer to the Privacy & Terms of Use section of jgbenefits.ca should I have questions as to the collection, use or disclosure of my personal information.