FORM 08
Change to Visual Acuity

Must be attached to: ***Form 07 - Extended Health Care Claim***

Please complete all information requested below, sign and return to Actra Fraternal Benefit Society (AFBS).

AFBS: 1000 Yonge Street
Toronto, ON M4W 2K2
PHONE: 416.967.6600 1.800.387.8897
FAX: 416.967.4744 1.888.804.8929
EMAIL: info@afbs.ca **WEB:** afbs.ca

AFBS WEST: 300 - 380 2nd Avenue West
Vancouver, BC V5Y 1C8
PHONE: 604.801.6550 1.866.801.6550
FAX: 604.801.6580
EMAIL: afbswest@afbs.ca **WEB:** afbs.ca

If you claimed the Vision Care benefit last Benefit Year, this form is required.

The Vision Care benefit provides reimbursement for the cost of prescription glasses or contact lenses, to a maximum amount every two Benefit Years. See your insurance program details for the percentage of reimbursement and maximum levels. Actra Fraternal Benefit Society (AFBS) recognizes the impact a significant change in your visual acuity can have on your life. If you or an insured dependant have a significant change in visual acuity that requires a new prescription, you may be eligible for an additional reimbursement regardless of whether a Vision Care expense has been claimed in the previous Benefit Year.

THIS IS NOT A CLAIM FORM.

SECTION 1 – Member Information *(please print)*

Reset Form

Member Name (Last, First, Middle Initial)

Date of Birth DD MM YYYY

Telephone Number

Your AFBS Account Number 4501 ☐ ☐ ☐ ☐ ☐ ☐

ACTRA/WGC Number (if applicable)

I participate in the following program (check one)

☐ Members' Insurance Program ☐ AFBS Staff Program ☐ Other _____

SECTION 2 – Please have your Optometrist or Ophthalmologist complete the following information.

Patient Name (Last, First, Middle Initial)

Doctor's Name

Office Telephone Number

Alternative: Office Stamp Here

Office Street Address

City

Province

Postal Code

I understand that my patient may be eligible for reimbursement of some Vision Care costs under the AFBS Extended Health Care program and I confirm there has been a significant change in visual acuity, warranting a new glasses/contact lens prescription.

Doctor's Signature (required)

Date DD MM YYYY

SECTION 3 - Member Authorization

I certify that the glasses/contact lenses purchased on the receipt accompanying my completed *Form 07: Extended Health Care Claim* contain the lens(es) prescription change confirmed above and that none of the reimbursement requested relates to the purchase of sunglasses.

I certify that I am authorized to disclose and receive information about my spouse and any dependants for purposes of assessing and paying a benefit, if any, and that any reimbursement will be paid to me.

Member's Signature (required)

Date DD MM YYYY

AFBS is committed to protecting the confidentiality of the personal information we collect from you and will use this information to assess your claim and administer the insurance program.

Note: The Benefit Year reimbursement is based on the date the receipt was issued. A receipt cannot be reimbursed over two Benefit Years. However, if in the second year an additional cost was incurred as a result of a change in visual acuity, a subsequent reimbursement may be made.

Include this form with your completed *Form 07: Extended Health Care Claim*, along with your receipt.