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Unit 1 Vision Care Claim Form

Claimant Information

Last Name: _____
 Given Name(s): _____
 Student/Employee No. _____ Phone: _____
 Email address: _____
 Mailing Address: _____

Have you made a claim in the last two years? Yes No
 If yes, amount: \$ _____

Amount of current claim (maximum \$250 per 24 months): \$ _____
Note: You must submit the original receipt (no copies).

Employment Information

Department: _____
 Course name: _____ Course Code: _____
 Term employed (refers to current academic year)
 Start month: Fall (September) Winter (January) Spring/Summer (May/June)
 End month: _____

Claimant Authorization

I submit this claim with the knowledge that any false information given will result in my immediate disqualification in this benefit plan and many result in further legal action.

Signature: _____ Date: _____

FOR OFFICE USE ONLY

CUPE Local 3906 Authorization

We certify that to the best of our knowledge the above claimant is a member in good standing and is entitled to this claim under the rules of the plan.

Signature: _____ Date: _____
 Position: _____