



# STF MEMBERS HEALTH PLAN VISION CARE CLAIM FORM

PLEASE SEE REVERSE FOR DETAILS ON HOW TO COMPLETE YOUR CLAIM FORM

## PART I – MEMBER INFORMATION

Plan Name STF MEMBERS HEALTH PLAN

Member Name \_\_\_\_\_ Date of Birth [YY][MM][DD] Member Identification Number \_\_\_\_\_

Home Mailing Address \_\_\_\_\_

CITY/TOWN \_\_\_\_\_ PROVINCE \_\_\_\_\_ POSTAL CODE \_\_\_\_\_

Phone Number \_\_\_\_\_ HOME \_\_\_\_\_ WORK \_\_\_\_\_

## PART II – CLAIMANT INFORMATION

Patient's First Name \_\_\_\_\_ Relationship to Plan Member  Self  Spouse  Child

Date of Birth [YY][MM][DD] \_\_\_\_\_

Children only, check if  Full-time post-secondary  Disabled

## PART III – COORDINATION OF BENEFITS (Please see reverse for complete instructions)

- Are you, or any other member of your family, entitled to benefits under any other group plan?  Yes  No  
 If "Yes", name of family member insured \_\_\_\_\_  
 Relationship to STF Member \_\_\_\_\_  
 Name of other insurance company \_\_\_\_\_  
 Group Policy Number \_\_\_\_\_
- Is your partner/spouse a teacher insured as a member under this plan?  Yes  No  
 If "Yes" to either question above, and the patient is a dependent child, please provide spouse/partner's birthday [MM][DD] \_\_\_\_\_
- Claims for members with a spouse/partner who is a teacher and has coverage under the STF Members Health Plan may, by answering the question below, provide for automatic coordination of benefits. Do you want this claim automatically coordinated under your spouse/partner's plan?  Yes  No  
 If "Yes", please provide your spouse/partner's Member Identification Number \_\_\_\_\_
- Is treatment required as the result of an accident?  Yes  No  
 If "Yes", give date, location and explain how accident happened \_\_\_\_\_
- Is a claim being made for Worker's Compensation Benefits?  Yes  No

## PART IV – VISION CARE SERVICES AND SUPPLIES AND PROVIDER STATEMENT

(This section must be completed, dated and signed by your provider of vision care services and supplies ONLY if your receipt(s) do not clearly itemize the services provided and indicated below. Please see reverse for complete instructions)

1.	Date of Service _____	EYE EXAMINATION \$ _____	
2.	Date of Service _____	SUPPLIES	TYPE OF LENSES
		Frames \$ _____	Single vision _____
		Lenses \$ _____	Bifocal/Trifocal _____
		Laser Surgery \$ _____	Progressive _____
		Other \$ _____	Safety _____
	Visual Training \$ _____	Reader _____	Contact _____
3.	Give description of "Other" in area 2 e.g.: Tinting, Varigray, Scratch Coating, Contact Lens Services, Repairs, etc. If glasses tinted, what was tint? _____		
4.	I am a legally qualified <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Optometrist <input type="checkbox"/> Optician		
	Signed _____	Date _____	
	Address _____	Telephone Number _____	

## PART V - MEMBER AUTHORIZATION

I certify that the statements in this claim are true and complete. I authorize the Saskatchewan Teachers' Federation, the STF Members Health Plan and its claim agents, and any person or organization who has relevant personal information about me or my dependents, to exchange information for the purpose of payment of claims, underwriting or administration of the plan.

Member Signature \_\_\_\_\_ Date \_\_\_\_\_

**SEE REVERSE**

## HOW TO SUBMIT YOUR CLAIM

1. Please complete a separate claim form for each family member for whom you are claiming expenses. You can also refer to the STF Website [www.stf.sk.ca](http://www.stf.sk.ca) to find additional assistance in completing your form.
2. Include your Member Identification Number on your claim form. It is the 10-digit number found on your prescription drug card, e.g. 0100000000. If you are a teacher on a temporary contract, you will not receive a prescription drug card. Your member identification number can be found on your confirmation of enrolment letter.
3. Attach original, itemized bills and official receipts for income tax purposes for all expenses. Staple receipts securely to back of claim form. Photocopies (unless submitting for co-ordination of benefits), carbon copies, credit card receipts or cash register receipts are not acceptable. A photocopy of your itemized receipt is required, along with the original Explanation of Benefit from the other insurance company, for Coordination of Benefits. Your original receipt(s) must clearly itemize the services and/or supplies provided and must clearly indicate the patient's name.
4. Bills and receipts are part of our records and will not be returned. Therefore, please retain copies of your receipts and the Explanation of Benefit that will accompany our cheque or explanation for your files and/or Income Tax purposes.
5. Mail your completed form directly to the claims office as indicated below.

## COORDINATION OF BENEFITS

It is important that your plan pays only for benefits for which it is responsible. This is done through a process called Coordination of Benefits.

Coordination of Benefits is a group health insurance policy provision designed to eliminate duplicate payments and determine the order for payment of benefits when there is coverage provided under a spouse/partner's or dependent's plan. Benefit payments may be coordinated with the benefits provided by any other plan to provide up to 100% of the eligible expenses, as long as the total amount received from all sources does not exceed the amount of the actual expenses incurred. A photocopy of your itemized receipt is required, along with the original Explanation of Benefit from the other insurance company, for Coordination of Benefits. Your original receipt(s) must clearly itemize the services and/or supplies provided and must clearly indicate the patient's name.

A spouse/partner who is covered under his/her employer's plan must first submit his/her claims to that plan and a university student who is covered under a university plan must first submit his/her claims to the university plan. Expenses for dependent children must first be submitted to the plan of the parent with the earlier birthday in the year. Part III Question 1 helps us determine the order of payment.

## VISION CARE SERVICES AND SUPPLIES AND PROVIDER STATEMENT

Please provide a complete breakdown of services and or supplies provided. Enter the information from your receipts onto Part IV - Vision Care Services and Supplies and Provider Statement on the reverse of this claim form. Your original receipt(s) must clearly itemize the services and/or supplies provided and must clearly indicate the patient's name.

This section must be completed, dated and signed by your provider of vision care services and supplies **ONLY** if your original receipt(s) do not clearly itemize the services provided as indicated in Part IV - Vision Care Services and Supplies and Provider Statement on the reverse of this claim form.

**NOTE:** Eye examination only does not require completion of Provider Statement by provider.

## REMINDER

Coverage expenses and limitations apply to each individual covered family member. Frequency limitations, i.e., 24- and 12-month consecutive periods, apply from the date of service or supply purchased. The frequency limit does not apply from your effective date of coverage. Please refer to your member information booklet for complete details.

If you are not sure when you have reached your 24- or 12-month frequency limit, please contact the claims office as indicated below.

**Please answer all questions and ensure your form is completed in full. This claim will be returned to you if it is incomplete, or contains errors, and will result in a delay in processing your claim. All claims under this group benefits plan must be submitted through, and signed by, the plan member.**

## WHERE TO SEND YOUR CLAIM

Send your claim to:

STF MEMBERS HEALTH PLAN  
PO BOX 1944 STN MAIN  
SASKATOON SK S7K 3S5

FOR CLAIM INQUIRIES, CALL  
Toll Free: 1-800-667-7762  
Phone: (306) 373-1660