



**VISION CARE CLAIM FORM
CLAIMANT STATEMENT**

Crawford & Company (Canada)
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+1-888-688-4344
equity@crawco.ca

SEE OVER FOR A LIST OF PARAMEDICAL/MEDICAL SERVICES/VISION CARE
Retain copies of all receipts/documents that are submitted with your claim, they will not be returned.

CAEA Member No.: _____

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

Legal Name of Claimant:		Date of Birth:
Address:		
City:	Province:	Postal Code:
Phone #: ()	Email Address:	
Is your membership in good standing and paid up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, you must ensure you are in good standing before you submit this claim).		
Production Name:		
Date Contract Signed:	Production's Last Performance:	
Have you submitted a claim under this Plan before? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you covered by another insurance company? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what is the name of that insurance company? What are your policy/Certificate numbers?		
If this claim is due to an accident, what was the accident date?		
Did the accident happen at work while under contract? <input type="checkbox"/> Yes <input type="checkbox"/> No		
How did it happen?		

Vision Care Provider Name: _____

Date Of Service _____

Description Service (e.g. eye exam, glasses): _____

AUTHORIZATION AND DECLARATION

I, the undersigned, hereby make claim for benefits under my employer's benefit plan adjudicated by Crawford & Company (Canada) Inc. I understand that any information provided to Crawford & Company (Canada) Inc., or their respective authorized agents, will be used in the initial adjudication and determination of my eligibility for benefits, claim and care coordination provisions under the terms of the policy, and potential entitlement to any extension of benefits under this claim.

I DECLARE that the statements provided by me in this authorization and declaration are true and complete, and given of my own free will.

I ACKNOWLEDGE that any person who knowingly files a statement of claim containing materially false, incomplete, or misleading information, or conceals any material facts with intent to defraud or deceive, may be guilty of a fraudulent act subject to civil or criminal penalties, and may be denied benefits related to their claim.

I AGREE that a reproduction of this authorization is as valid as the original.

Claimant Signature _____ Date _____

VISION CARE CLAIM FORM

CHECKLIST

Before you submit a completed claim form, please review this checklist to avoid any delay in processing of your claim:

- Have you fully completed and signed the appropriate claim form (i.e. Vision, medical, paramedical)?
- Is your membership with Canadian Actors' Equity Association current and in good standing (fully paid up)?
- Have you attached an official receipt (do not submit a cash register receipt) confirming the type of treatment, date of treatment, name/qualification? Does it include the service provider's signature?
- Have you retained copies of all your receipts? Crawford WILL NOT return any hard copy receipts to you.

VISION CARE:

- Eye exams, Prescription glasses, Contact lenses (as per plan booklet limits)

FOR A COMPLETE LISTING OR COVERED SERVICES, PLEASE SEE PLAN BOOKLET WORDING

