INSULATORS LOCAL 95 BENEFIT FUND VISION CARE STATEMENT OF CLAIM

MAIL ALL CLAIM FORMS TO: BENEFIT PLAN ADMINISTRATORS LIMITED P.O. Box 3071, Station 'A' Mississauga, Ontario L5A 3A4

To be completed by Member

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No. and Street City Province						Postal Code ()							
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I certify that the above information is true, correct and complete. I authorize Benefit Plan Administrators Limited ("BPA") to collect and use personal information about me and/or my eligible dependents to process this claim and administer my benefit plan. I am aware BPA will keep my personal information confidential and safeguarded.

I am aware that BPA will only release personal information to my eligible dependents specific to their benefit entitlements. I understand that my personal information (and the personal information of my eligible dependents) may only be shared with health care practitioners, medical facilities, providers of health care/dental services or benefits administration services, provincial health insurance plans, insurance carriers, government agencies, and auditing or independent investigative organizations in order to verify eligibility for my benefit entitlements.

I understand that my social insurance number will be kept in strictest confidence and will only be used for income tax reporting purposes and to match my information with the correct member file. I consent to the collection, use and disclosure of personal information as stated above.

Member's Signature _

Date (DD / MM / YY)