A LIST ONLY

MCSTC Eye Exam Reimbursement Form

To be completed by the plan member unless otherwise indicated. Original receipts must be attached for all expenses: Please retain copies for your files as original receipts will not be returned.

1. Plan member information (Toronto District School Board Employee number)

_____

Plan member name (first, middle, last)

_____

Mailing Address City/Town Province Postal Code

_____ _____ _____ _____

Are you, your spouse or dependents covered under any other plan for expenses being claimed?

o Yes o No If "**yes**" please provide the following:

Spouse's D.O.B (dd/mm/yyyy) Patient's name

_____ _____

Are these expenses eligible for coverage under any type of worker's compensation board?

o Yes o No

2. Patient Information

Patient's Name	D.O.B (dd/mm/yyyy)	Relationship	Date of bill	Total ($)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

3. Plan member confirmation

I CERTIFY that the foregoing answers and the information contained in the other documents supporting this claim for benefits are, to the best of my knowledge and belief, trust, full and complete. Willful misrepresentation could be considered fraud and subject to penalties.

Signature of plan member Date (dd/mm/yyyy)

_____ _____