

Claim Number

A. Worker Information

Last name		First name		Initial	
Current address		City	Province	Postal Code	Is this a new address? <input type="checkbox"/> yes <input type="checkbox"/> no
Home phone		Work phone		Birth date (mm/dd/yyyy)	

B. Provider Information

Provider name			Stamp or Label		
Address: City		Province	Postal Code	Business phone	

C. Damage for Repair/Replacement Entitlement ONLY (Provider to complete the following)

Single Vision Lens(es) <input type="checkbox"/> yes <input type="checkbox"/> no		Hardex Lens(es) <input type="checkbox"/> yes <input type="checkbox"/> no		Tint <input type="checkbox"/> yes <input type="checkbox"/> no	
Other - specify type			Bifocal - specify type		
Prescription: Right Eye (OD)			Left Eye (OS)		
Was there damage done to:					
Lens(es): <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both <input type="checkbox"/> none		Frame: <input type="checkbox"/> yes <input type="checkbox"/> no			
Is the replacement frame similar to damaged frame? <input type="checkbox"/> yes <input type="checkbox"/> no			If not, is it of equal value? <input type="checkbox"/> yes <input type="checkbox"/> no		
Cost of original lens(es)? \$		Cost of replacement lens(es)? \$		Cost of original frames? \$	
				Cost of replacement frames? \$	
Total cost worker paid and is requesting reimbursement for? \$					
Provider Signature				Date (mm/dd/yyyy)	

D. Prescription Information - Optometrist to complete ONLY (if vision entitlement exists)

		Sphere	Cylinder	Axis	Prism	Add
New RX	Right					
	Left					
Old RX	Right					
	Left					
Plastic <input type="checkbox"/>		Type of right lens _____				
Hardened <input type="checkbox"/> chem		Type of left lens _____				
<input type="checkbox"/> heat		Tint _____				
		Oversize: _____ mm				

initial prescription prescription sunglasses Rx duplicate
 new prescription contact lenses replacement (loss or breakage)
 safety glasses lenses only
 post cataract
 other: (indicate any medical conditions or disease) _____

If claim is for contact lenses:
 Can visual acuity be restored to 20/70 ? 20/40 ?
 Are the contact lenses medically necessary due to keratocunus, irregular astigmatism, aphakias or irregular corneal curvature? yes no
 Can visual acuity be improved by at least two lines on the Snellen chart over the best possible vision with glasses? yes no

Provider Signature		Date (mm/dd/yyyy)
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E. Worker Declaration

I hereby certify, that to the best of my knowledge, the information provided on this form is true, accurate and complete, and that the expenses listed were for myself and for my WSIB related claim. I agree to retain all original receipts and provide them to the WSIB with this form. For the expenses paid for by the WSIB, I will not request reimbursement from any other insurers/organizations. I also authorize the release of any information to the WSIB relating to the expenses and information listed on this form.

Signature	Date (mm/dd/yyyy)
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