ID#_____

Benefit Assignment Form

Instructions: This form must be filled out when claim payment is assigned to the Provider. Please retain this form in the patient's file.

Provider: _Regal Eye Care_____
Address: _101 - 50 Rolling Hills Drive_____
City/Province: _Orangeville, ON_____
Postal Code: _L9W 6T6_____
Phone Number: _519 - 307 - 7771_____

MEMBER NAME: _____

Dependent 1: _____

Dependent 2: _____

Dependent 3: _____

Dependent 4: _____

Address: _____
City/Province: _____
Postal Code: _____
Phone Number: _____
D.O.B of Member.: _____
Insurance: _____
Plan Number: _____
Certificate / Plan Number: _____

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

_____ _____

Date: Signature

Print Name (Parent or Guardian if under the age of 18):