REGAL EYE CARE

BENEFIT OF ASSIGNMENT FORM

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 (If Applicable) **:** _____
Dependent 2 (Optional): _____
Dependent 3 (Optional): _____
Dependent 4 (Optional): _____

Address: _____
City/Province: _____
Postal Code: _____
Phone Number: _____
Date of Birth of Member (mm/dd/yy): _____
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.

/2024 _____ _____

Date (mm/dd/yy) **Signature**