DeCare Vision Claim Form

OFFICE USE ONLY

SECTION A - Policyholder and patient details

Vision policy number: ☐☐☐☐☐☐☐☐☐

Policyholder's name: .....

Policyholder's date of birth: D D M M Y Y

Policyholder's address: .....

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Patient's name: .....

Patient's date of birth: D D M M Y Y

Relationship to policyholder: .....

Mobile contact number: .....

(By providing your mobile number you agree to receive free SMS text updates on the status of this claim and your product benefits)

Email: .....

(By providing your email address, you agree to receive email updates in relation to the status of your claim and information in relation to existing products or services)

SECTION B - Your payment details

We will send your payments directly to your bank account. Please ensure that you complete your bank account details.

IBAN:

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BIC: ☐☐☐☐☐☐☐☐☐☐☐

Bank name and address:

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SECTION C - Declaration

Please ensure that you sign and date the claim form.

I declare that the expenses and details submitted in this form were incurred by me and/or members covered under the vision policy. I declare that to the best of my knowledge, the information contained on this form is true in every respect. I consent to DeCare Vision's use of the information on this form for the administration of my vision coverage. I understand that I am responsible for all costs of vision treatment.

Policyholder's/Member's signature (Legal guardian if under age 18): X

(You must sign and date the claim form)

Date: D D M M Y Y

DATA PROTECTION NOTICE

We hold and use personal data and sensitive personal data such as medical information for the purposes of providing and administering dental insurance products. We are registered as a data controller with the Office of the Data Protection Commissioner. In order to administer the vision insurance products which we provide, it is necessary for us to send your data outside of the EU to our parent company and trusted third parties based in the USA but such data will continue to be safe guarded in accordance with the standards and principles set out in the EU General Data Protection Regulation (GDPR). We may share your personal data and sensitive personal data with your provider insofar as it is relevant to the processing of your claim. We may share your personal data with our bank for the purpose of processing the payment of your claim. We may also share your data with other insurers to verify your cover. We may share your data with trusted third parties for the purpose of the processing of your claim and distributing policy documentation and other communications, such as letters, direct mail, emails etc. We may share your information with our parent company and other group companies for the purpose of processing the payment of your claim and efficient administration such as audit, systems development etc. We may share your personal data and sensitive personal data with our legal advisers and the appropriate authorities where necessary e.g. An Garda Síochána and in relation to personal data with the Revenue Commissioners. We may share your personal information and anonymised information for the purposes of health services research for projects approved by the Data Protection Commissioner. If you have a query in relation to the data held about you or you wish to request a copy of the data held by DeCare about you, please write to the Data Protection officer, DeCare Vision IDA Business Park, Claremorris, Co. Mayo.

Checklist Don't Forget!

Please ensure the following is completed so we can assess your claim.

- ☐ Did you attach your receipts? (please do not send laser/credit card slips)
- ☐ Did you make copies of your receipts for your own records? It is not our policy to return original receipts.
- ☐ Provide your bank account details
- ☐ Ensure you include all relevant treatment details required in section D
- ☐ Sign & date your claim form

PLEASE NOTE: If your Provider provides ALL of the required information in the receipt and you include this original receipt with your claim form, you **DO NOT NEED** to fill in Section D of the claim form.

Your claim must be submitted within 12 months of the date of completion of treatment. Claims submitted after this period can not be accepted and benefits will not be paid. We will issue a vision claim statement to you when your claim has been processed. This statement will provide a breakdown of payments made to you.

Get in touch

T: 1890 130 017 / 094 93 78608 | E: vision@decare.com | www.decarevision.ie

DeCare VISION

POST TO: Claims Department, DeCare Vision,
IDA Business Park, Claremorris, Co Mayo, F12 KD85

Attach your receipts here.

SECTION D - Treatment Details

Section D may list treatments that are not covered by your particular vision policy. Please refer to your Schedule of Benefits and Terms and Conditions Booklet for full details of your cover.

Please ask your Provider for assistance in completing this section.

Treatment	Date of Service	€ Fee
Exam Eyewear		
Exam Contact Lenses		
VDU Assessment		
Frame		
Contact Lenses		
Contacts Lense Fittings		
Lenses		

Lens Type (please tick)	Lens Options (if purchased)	€ Fee
☐ Single ☐ Bi-Focal ☐ Tri-focal ☐ Progressive ☐ Prem Prog	Anti-Reflective	
	Polycarbonate	
	Scratch	
	Tint	
	UV	
	Roll and polish	

Enter Total Amount paid as shown on receipt:	€

SECTION E - Your provider details

Please fill in the name and address of the provider you attended and have your provider sign the claim form.

Provider's name:

Provider's telephone number:

Provider practice address:

Provider's signature: X

January 2020

For claim or benefit queries, contact the DeCare Vision customer support team on **1890 130 017** or **094 93 78608**.