



STUDENT'S STATEMENT														
Student's Name	Student Number	Account Number												
	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">O</td> <td style="width: 20px; height: 20px; text-align: center;">T</td> <td style="width: 20px; height: 20px; text-align: center;">T</td> </tr> </table>									O	T	T	1480	
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Patient's Name	Relationship to Student		Patient's Birthday											
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child													
Student's Address:	email:	Tél.:												
A SEPARATE FORM MUST BE COMPLETED FOR EACH PATIENT														
Part I Vision Care - Part II Hearing Aid Expenses - Part III Other Expenses (reverse side)														
Part I VISION CARE EXPENSES														
To be completed by an optometrist or optician when claiming for an eye examination or eye glasses														
CHARGES		LENSES												
Eye Examination _____		New Prescription <input type="checkbox"/>												
Frames _____		Repeat Prescription <input type="checkbox"/>												
Lenses _____		Safety Lenses <input type="checkbox"/>												
Other _____		Plastic Lenses <input type="checkbox"/>												
Total _____		Sunglasses <input type="checkbox"/>												
		Tint Number _____												
_____ Date of Service		_____ Signature of Optometrist or Optician												
Part II HEARING AID EXPENSES														
Section (A) to be completed by Physician; Section (B) to be completed by Student														
(A) PHYSICIAN'S STATEMENT														
(to be completed by a physician, who has been certified as an audiologist)														
This is to certify that I have ordered a hearing aid for the above patient on			_____ Date											
Diagnosis _____														
Type of Hearing Aid prescribed _____														
Did the Patient ever wear a Hearing Aid previously?		<input type="checkbox"/> YES <input type="checkbox"/> NO												
_____ Physician's Signature														
(B) STUDENT'S STATEMENT														
(To be completed by the student. A bill or receipt, giving the date of purchase, patient's name, and amount, must accompany your claim).														
Date of Purchase	Type of Hearing Aid	Account Charges	Purchased Form											
N.B.: This is a standard form. The benefits named do not apply to all students. This form as well as all original receipts must be Forwarded to Assumption Life at the following address: Box 160/770, Main Street, Moncton NB, E1C 8L1														

