



Optical Claim Form

Please use BLOCK CAPITALS and Black Ink when completing the form.

Once completed you can upload this together with a copy of the invoice and your current prescription via our on-line claims portal at www.expacare.com/submit-a-claim. Please contact us on +44 (0) 1344 233900 if you have any questions.

			Last nar			
Telephone:			Email:			
Membership N	umber:		Date of	birth: DD / N	IM / YY	
Date of eye tes	t:					
as your prescrip	tion changed sinc	e your last eye tes	t?: Yes	No		
			t?: Yes	No		
	tion changed sinc		t?: Yes	No		
e provide a cop	by of your current	prescription:		1	Add	
			Yes Axis	No	Add	
e provide a cop	by of your current	prescription:		1	Add	
e provide a cop	by of your current	prescription:		1	Add	
e provide a cop	by of your current	prescription:		1	Add	

I have included the following:

Copy of invoice

Copy of current prescription