



## Optical Claim Form

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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](http://www.expacare.com/submit-a-claim). **Please contact us on +44 (0) 1344 233900 if you have any questions.**

|                    |                             |
|--------------------|-----------------------------|
| First name:        | Last name:                  |
| Telephone:         | Email:                      |
| Membership Number: | Date of birth: DD / MM / YY |

|                      |  |
|----------------------|--|
| 1. Date of eye test: | 2. Has your prescription changed since your last eye test: |
| .....                | .....  |
| .....                | .....  |
| .....                | .....  |

3. I have included the following:

- Copy of invoice
- Copy of current prescription