Crescent Employee Benefits
Crescent Dental Plans®

# Application for Group Vision

Underwritten by Companion Life Insurance Company

## BENEFIT HIGHLIGHTS

**Eyemed Access Network**

| | DESCRIPTION | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|---|
| **Exam** | Exam with dilation ( as necessary) | $10 Copay | $35 allowance |
| **Contact Lens fit and follow- up** | Contact lens fit and two follow- up visits are available once a comprehensive eye exam is complete. | Standard $0 copay<br>Premium* 10% off retail then apply $55 allowance | Standard $40 allowance<br>Premium*** $40 allowance |
| **Frames** | Any available frame at provider location | $130 frame allowance, 20% off balance over allowance | $72 allowance |
| **Standard Plastic Lenses** | Single<br>Bifocal<br>Trifocal | $10 copay<br>$10 copay<br>$10 copay | $25<br>$40<br>$55 |
| **Lens Options:** | UV Coating<br>Tint ( solid and gradient)<br>Standard Scratch resistant coating<br>Standard Polycarbonate<br>Standard Anti-Reflective Coating<br>Standard Progressive ( Add- on to bifocal)<br>Other add-ons and services | $15<br>$15<br>$15<br>$40<br>$45<br>$75<br>20% off retail | Discount available only at Network providers and retailers. |
| **Contact Lenses:** (Conventional and Disposable) | Material Only<br><br><br>Medically necessary | $0 copay<br>$120 allowance<br>15% off balance over allowance (conventional only)<br>Paid in full | $96 allowance<br><br><br>$200 allowance |
| **Benefit Frequency** | Exam<br>Lenses<br>Frames | 12 Months**<br>12 Months**<br>12 Months** | 12 Months**<br>12 Months**<br>12 Months** |

* Premium Contact Lens Fitting all lens designs, materials and specialty fittings other than Standard ( ex. Toric, multifocal, etc.)
** Once in a 12 month period defined by last date of service. ( Contact Lens in lieu of eye glass lenses).
This is merely a summary of benefits. Limitations and exclusions apply

## ENROLLMENT INFORMATION

**Information below must be completed by each participating employee, signed and dated.**

| | | | | |
|---|---|---|---|---|
| Name of Employer: **University of Louisiana at Lafayette** | | | Division: | **Group # 9671215** |
| Hire Date: | Eff. Date: | Occup. | Date of Birth: | SSN #: |
| Employee Name: | | | | Hm. Ph: |
| First | | Middle | Last | Are you working at least 30 hours per week? ❒ Yes ❒ No |
| Home Address: | | | | |
| Gender: ❒ M ❒ F | Number | Street | City State Zip | |

Coverage Applied*: ❒ $7.17 + .22 = $7.39 Employee Only ❒ $18.10 + . 55 = $18.65 Employee + Family

**Above are the monthly premiums plus the Health Insurance Industry Fee required by the Affordable Care Act (ACA).**

*Please provide information below for all dependents to be covered under your Vision plan.*

| | Name | Date of Birth | Gender |
|---|---|---|---|
| Spouse | | | |
| Child | | | |
| Child | | | |
| Child | | | |
| Child | | | |

**Monthly premiums are based on 12 pay periods per year and are guaranteed until the next policy renewal date.*

I have completed this form to the best of my knowledge and understand that Companion Life is relying on the truth and accuracy of the information provided. Furthermore, I authorize my employer to deduct my share of the premium from my earnings. 01/2015

_____ _____

Signature of Employee Date

# Crescent Vision Plan

* I hereby apply for Group Vision Insurance as presented to me.
* I further represent that I am not presently disabled and I am performing all the duties of my occupation at least 30 hours per week.

☐ **I have been given an opportunity to apply for Group Vision Insurance, but do not wish this coverage available to me because:**

☐ I am insured with another policy or group plan (please indicate below)

Employer's Name _____ Carrier Name _____

☐ Other reasons

Dated this _____day of _____20_____. _____
Individual's Signature

***An employee can only enroll in the plan within 31 days of becoming eligible or during the group's Annual Open Enrollment period, unless there is a Qualifying Event.***