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 Premium* 10% off retail then apply $55 allowance	Standard $40 allowance Premium*** $40 allowance
Frames	Any available frame at provider location	$130 frame allowance, 20% off balance over allowance	$72 allowance
Standard Plastic Lenses	Single Bifocal Trifocal	$10 copay $10 copay $10 copay	$25 $40 $55
Lens Options:	UV Coating Tint (solid and gradient) Standard Scratch resistant coating Standard Polycarbonate Standard Anti-Reflective Coating Standard Progressive (Add- on to bifocal) Other add-ons and services	$15 $15 $15 $40 $45 $75 20% off retail	Discount available only at Network providers and retailers.
Contact Lenses: (Conventional and Disposable)	Material Only Medically necessary	$0 copay $120 allowance 15% off balance over allowance (conventional only) Paid in full	$96 allowance $200 allowance
Benefit Frequency	Exam Lenses Frames	12 Months** 12 Months** 12 Months**	12 Months** 12 Months** 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:	Occupation:	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 (*monthly rates): ❒ $7.17 Employee Only ❒ $18.10 Employee + Family

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

	Name	Date of Birth	Gender
Spouse			
Child			
Child			
Child			
Child			

**Rates 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.

_____ _____

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.