Crescent Employee Benefits
Crescent Dental Plans

Application for Group Vision

Underwritten by Companion Life Insurance Company

BENEFIT HIGHLIGHTS

Crescent Vision Benefits with Evemed 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	$100 frame allowance, 20% off balance over allowance	$45 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 $80 allowance 15% off balance over allowance (conventional only) Paid in full	$64 allowance $200 allowance
Benefit Frequency	Exam Lenses Frames	12 Months** 12 Months** 24 Months	12 Months** 12 Months** 24 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 & exclusions apply.

ENROLLMENT INFORMATION

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

Name of Employer: **HOLMES COMMUNITY COLLEGE**			**Group Number: CR567**	**Policy Number: 9671215**
Hire Date:	Eff. Date:	Occup.	Date of Birth:	SSN #:
Employee Name:				
First	Middle	Last		king at least No
Home Address:				
Gender: ☐ M ☐ F	Number Street	City		
Coverage Applied*:	___ $5.74 Employee Only ___ $12.78 Employee + Two		$10 ee + 17.01 ily	

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

		Date of Birth	Gender
Spouse			
Child			
Child			
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**Above are monthly premiums based on 12 pay periods per year and premiums 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. 9/2020

Signature of Employee _____ Date _____