The Eye and Vision Center Eyecare Advantage Program Enrollment Form

Please Fax to 888-299-4619 when completed

Company Name _____ Contact _____

Address _____ Phone _____

City _____ State _____ Zip _____ Fax _____

Email Address _____

Number of employees _____

This company would like to enroll in The Eye and Vision Center Eyecare Advantage Program. We have chosen the following payment options:

- ☐ The Company will pay for one comprehensive eye exam every ☐ 12 ☐ 24 months for all employees, and employees will pay for all dress eyewear and contact lenses at the discounted rate.
- ☐ The Company will pay for one comprehensive eye exam every ☐ 12 ☐ 24 months for all employees plus $_____ towards dress eyewear or contact lenses every ☐ 12 ☐ 24 months.
- ☐ All employees will pay for their own eye exams and dress eyewear/contact lenses at the discounted rate.

The company will pay for the following for employee's spouse/dependent children:

- ☐ Exam: one comprehensive eye exam every ☐ 12 ☐ 24 months
- ☐ Dress Eyewear: $_____ every ☐ 12 ☐ 24 months
- ☐ Contact Lenses: $_____ every ☐ 12 ☐ 24 months

The employee's spouse/dependent children will receive the same discounted rate regardless of the options chosen above.

If the company will pay for any amount of the employee's eyecare, please fill out the separate payment agreement form.
