CONTACT LENS FORM FOR VISION PLAN USERS

1. Last Name: 2. First Name:
2. Date of birth:
3. Address to ship lenses:

   City: State: Zip:
4. Phone number:
5. E-mail:
6. Which Insurance plan will you be using (Circle your plan) - VSP, EyeMed, HumanaComp Benefits, Spectera, Davis Vision, NVA, VBA, or Superior Vision Plan.
7. If the insurance is NOT under your name, to verify insurance benefits we need the name of the primary insured.

   Last Name: First Name:

   Date of Birth: / / 19 ____ Last 4 numbers of the Social Security:
8. Which Brand lenses are you planning to order (circle one): Alcon, Bausch & Lomb, Cooper Vision, Vistakon, X-Cel Contacts.
9. Tell us which series you are ordering for the right eye:

   left eye:
10. Number of boxes for the right eye: left eye:
11. Do you remember what the total amount was for the lenses on the website prior to checking out.? $______________$. We will find out what your insurance covers, SUBTRACT BENEFITS FROM THE AMOUNT. The insurance may cover the entire supply, if there's an overage how should we reach you to pay the difference (Circle one); Call, or E-mail.
12. Once completed please sign and e-mail the form back to: icareteam@premieropticalgroup.com

I affirm that all the information herein is of the insurer true and correct to the best of my knowledge. I understand that any misrepresentation or falsification may render this form request void:

Signature____