PRESCRIPTION SAFETY EYEWEAR - AUTHORIZATION FORM (*LARGE VOLUME*)

WALMAN OPTICAL #040 (800) 926-9276

EMPLOYER INFORMATION

Form Last Revised: ***12/17/2015***

Account #27651
I B E W LOCAL 110
ST PAUL WORKERS HEALTH PLAN
1330 CONWAY ST STE 130
SAINT PAUL, MN 55106-5856

EMPLOYEE INFORMATION

EMPLOYEE NAME (Last Name, First) ____________________

EMPLOYEE ID NUMBER ____________________ EMPLOYEE PHONE NUMBER ____________________

DEPARTMENT NUMBER ____________________ COST CENTER NUMBER ____________________

DISPENSER / EYE CARE PROVIDER

Enter Account Number, Complete Address, and Phone Number

Y=*Allowed*, **N**= *Not Allowed*, **I**= *Included. Column headings indicate payment responsibility. Reference Industrial Safety Eyewear Price List* ***"LARGE VOLUME"***

	EMPLOYER RESPONSIBILITY	EMPLOYEE RESPONSIBILITY: Pay to Employer	EMPLOYEE RESPONSIBILITY: Pay to ECP or Lab
LENSES			
SINGLE VISION			Y
LINED BIFOCAL OR TRIFOCAL			Y
PERCEIVE HD PROGRESSIVE			Y
OTHER DIGITAL PROGRESSIVE			Y
OTHER COMPUTER PROGRESSIVE			Y
DOUBLE SEGMENT OR QUADRIFOCAL			Y
LENS MATERIALS			
TRIVEX 1.53			Y
POLYCARBONATE			Y
PLASTIC			Y
GLASS			Y
FRAMES			
PACKAGE FRAME **"BASIC"**			I
FRAME UPGRADE			Y
SIDESHIELDS DETACHABLE			Y
SIDESHIELDS PERMANENT			Y

	EMPLOYER RESPONSIBILITY	EMPLOYEE RESPONSIBILITY: Pay to Employer	EMPLOYEE RESPONSIBILITY: Pay to ECP or Lab
LENS ENHANCEMENTS			
SENTINEL+UV OR OTHER NON-GLARE TREATMENT			Y
ANTI-FOG TREATMENT			
HARDCOAT SCRATCH PROTECTION (TD2 or Foundation XT)			Y
COMPUTER VISION SYNDROME (Non-Glare and Solid Tint)			Y
TRANSITIONS (Photochromic)			Y
POLARIZED			
SOLID TINT (INDOORS - Shade #1 or Lighter)			I
SOLID TINT (INDOORS - Shade #2)			I
SOLID TINT (OUTDOORS - Shade #3 or Darker)			Y
PLASTIC LENS CR-39 UV PROTECTION			Y
PLASTIC LENS CR-39 SCRATCH PROTECTION *(FRONT & BACK)*			Y
GLASS LENS MATERIAL – PHOTOCHROMIC			Y
EYECARE PROVIDER SERVICES			
DISPENSING FEE **$20.00**			Y

EMPLOYER AUTHORIZATION

Form Last Revised: ***12/17/2015***

X ____________________
AUTHORIZATION SIGNATURE (Print and Sign) DATE

Plan Office Representative Ext.750 (651) 776-4239

SPECIAL INSTRUCTIONS/PROGRAM NOTES:

Members are responsible for the complete cost of prescription safety glasses, the dispensing fee and handling charge, payable to the eye care provider at the time of order.
For reimbursement member must file a claim as an out-of network claim through VSP. Form available at the Plan Office or online at www.ibew110.org/asc. You are only eligible for benefits under VSP one time per calendar year using either a Network or a Non-Network provider. Benefits cannot be split between Network and Non-Network services.

ORDER FORM

LENSES

SINGLE VISION ☐

LINED MULTIFOCAL ____________

PERCEIVE HD* ____________
Regular, Short, Wrap, or Office

* *specify OC Height when Rx is for Perceive HD or other digital progressive lens designs*

	SPHERE	CYLINDER	AXIS	PRISM
R				
L				

	ADD	SEG HT	OC HT	DIST PD	NEAR PD
R					
L					

LENS MATERIALS

TRIVEX 1.53 ☐

POLYCARBONATE ☐

CR-39 PLASTIC ☐

GLASS 1.523 ☐

LENS ENHANCEMENT OPTIONS

TRANSITIONS ☐ Gray ☐ Brown Other ____________

ANTI-FOG ☐ TD2 Optifog ☐ Crizal Optifog Other ____________

NON-GLARE ☐ Sentinel+UV Other ____________

HARD COAT ☐ TD2 or FoundationXT ☐ HCW *(scratch warranty ONLY… Add-on for non-glare order)*

INDOOR TINT ☐ Solid #1 ☐ Solid #2 Color ____________

OUTDOOR ☐ Solid #3 ☐ Polarized Color ____________

Z87-2+ FRAME INFORMATION

☐ LENSES ONLY ☐ LAB TO SUPPLY FRAME

☐ FRAME TO COME TO LAB ☐ FRAME ENCLOSED WITH ORDER

________ MANUFAC TURER ________ FRAME NAME ________ COLOR ________ SIZE

SIDESHIELDS ☐ DETACHABLE ☐ PERMANENT ADDITIONAL SIDESHIELDS ________ QUANTITY

LAB INFORMATION *MAIL OR FAX THIS FORM TO THE LAB*

WALMAN OPTICAL #040
9200 WYOMING AVE N
MINNEAPOLIS, MN 55445
MAILING ADDRESS

JEFFREY MARCELLA
INDUSTRIAL SAFETY EYEWEAR
SALES REPRESENTATIVE

(800) 926-9276
LAB PHONE NUMBER

(888) 976-5646
LAB FAX NUMBER

EMPLOYEE RESPONSIBILITY

Eyecare Provider: Write any amount NOT COVERED BY THE EMPLOYER. *(If Employer covers a maximum amount, enter ALL Item Costs and subtract the employer's portion.)*

LENS PACKAGE $ ____________

STYLE/MATERIAL ADD-ON $ ____________

COLOR ____________ $ ____________

COAT ____________ $ ____________

COAT ____________ $ ____________

FRAME $ ____________

SIDESHIELDS $ ____________

DISPENSING FEE $ ____________

HANDLING CHARGE $ ____________

EMPLOYEE TOTAL $ ____________