GVS | GENERAL® VISION SERVICES

CSA Welfare Fund

First Name: _____ Last Name: _____ ID #: _____

Account #: _____ Service Date: _____ Store Code: _____

BENEFIT OUTLINE	CO-PAYS	PATIENT PAYS
EYE EXAMINATION		
Provider Office **MUST NOT Bill Medical Insurance Plan** for Comprehensive Eye Exam or Office Visit		
☐ Eye Examination (includes tonometry)	Included	
☐ Dilation (when professionally indicated)	Included	
FRAME ALLOWANCE		
☐ GVS Collection Frame	$200 allowance	
☐ Non-Collection Frame	$150 allowance	
SPECTACLE LENSES		
☐ Single Vision	Included	
☐ Flat Top FT28 & FT35	Included	
☐ Trifocals	Included	
☐ Oversize	Included	
☐ Standard Progressive	Included	
☐ Premium Progressive	$80	
☐ Deluxe Progressive	$120	
MATERIALS		
☐ Plastic Lenses	Included	
☐ Polycarbonate	$30	
☐ Polycarbonate for kids (up to 16 years of age)	Included	
COATINGS		
☐ Cosmetic Tint	Included	
☐ Sunglass Tint	Included	
☐ Scratch Resistant Coating	Included	
☐ UV Coating	Included	
☐ Anti-reflective Standard Coating	$40	
☐ Anti-reflective Premium Coating	$90	
☐ Plastic Photosensitive Single Vision	$65	
☐ Plastic Photosensitive Bifocal	$95	
☐ Hi-Index Single Vision	$55	
☐ Polarized	$95	
CONTACT LENSES		
Colored Contact Lenses are **NOT** included. Fitting and Dispensing Included for the following Lenses.		
☐ Spherical Disposables 6 Month Supply	Included	
☐ Non-Covered Contact Lenses	$150 allowance	
☐ Fitting Fee for Upgraded Lenses	$50 co-pay	
ANY SERVICE NOT LISTED ABOVE RECEIVES A 30% DISCOUNT		
List any additional upgraded services below		
TOTAL PATIENT RESPONSIBILITY		

By signing below, I acknowledge that I have received the above services and materials and that I am responsible for the amount listed above.

Patient Signature: _____