

INSTRUCTIONS FOR ORDERING PRESCRIPTION PROTECTIVE EYEWEAR

LOCAL OFFICE PROCEDURE

Note: It is suggested and recommended the employee utilize one of the Provider Panel Members, since payment for the fitting of the eyewear will be managed by **U.S. SAFETY**. Therefore, there will be no payment required to the Provider Panel Member by the employee.

The employee & supervisor **MUST** complete the **BILL TO** section of this form:
(Please Print All Information)

- * Employee Name
- * Verizon Supvr.
- * Contact Phone Number
- * M/C Card Holder's Name (Please Print)
- * M/C Card # Expiration
- * Card Holder Signature
- * Dept. Number

The employee **MUST** take this form to practitioner for completion and return it to their supervisor for approval.

Completed form **MUST** be **FAXED TO: U.S. SAFETY, 1-800-428-7304**

If the employee chooses a frame or special lens that REQUIRES CO-PAYMENT, they MUST ATTACH A CHECK MADE PAYABLE TO U.S. SAFETY and mail to: U.S. Safety, 8101 Lenexa Drive, Lenexa, KS 66214 OR FILL IN PERSONAL CREDIT CARD INFORMATION in space provided on order form and fax to U.S. Safety.

MEMO TO EMPLOYEE

Take prescription form to practitioner of your choice. The Provider Panel Member locations have the approved frames for selection.

It is important to have your doctor select the type of progressive lens which best meets your vision requirements.

Return form to your Supervisor for processing and approval.

Payment for the eye exam is the responsibility of the employee.

MEMO TO EYE PRACTITIONER

This employee is being furnished a pair of protective eyewear made in compliance with the American National Standards requirement (Z87.1) for industrial use to protect against eye injury on the job as specified in the Occupational Safety and Health Act.

Please complete the **REFRACTIONIST** and **SHIP TO** sections of this form.

No substitute items or styles are permitted unless for professional reasons and authorized by the Manager - Safety and Compliance Services.

We will arrange to have the eyewear made by U.S. Safety, and sent directly to you to verify for accuracy and for fitting. Please notify the employees' District Office (contact indicated on this form) upon arrival of the eyewear.

Payment of the eye exam is the responsibility of the employee.

BASEFRAMES

Phoenix II, Glider, Aviator

EMPLOYEE CO-PAYMENT FOR UPGRADED FRAME & LENS OPTIONS

| | | | |
|-------------------------------|---------|-----------------------|---------|
| PC264, PC267 | \$27.00 | Newport | \$20.00 |
| Essex - Titanium | \$50.00 | Progressive Lens - | \$15.00 |
| Titmus Premiere Collection - | \$27.00 | Progressive Sola VIP | \$25.00 |
| Titmus Exclusive Collection - | \$40.00 | Progressive Varilux - | \$50.00 |
| Titmus Titanium Collection - | \$74.00 | Transition - | \$40.00 |

U.S. SAFETY

Division of Parmelee Industries, Inc.

8101 LENEXA DRIVE P.O. BOX 15965 LENEXA, KS 66285-5965
913-599-5555 1-800-821-5218 Rx FAX 1-800-428-7304 In Kansas FAX 1-913-599-1703

Bold Boxed Areas MUST Be Completed To Process This Order.
PLEASE PRINT

S Name/Office _____

H Address _____

I City _____ State _____ Zip _____

Eyewear MUST SHIP Back To Doctors Office

B Employee Name _____ P.O. No. _____
(please print)

L Verizon Supervisor _____

L Contact Phone Number _____ Dept. Number _____

Mastercard Holder Name _____
(please print)

Card Holder Signature _____

Mastercard Number _____ Exp. _____

| | | | | | | | | |
|--|--------------------|---|---|----------------------|----------------------|---|--|--------------------------------|
| Lens Material PLASTIC | | Clear | Tints <input type="checkbox"/> Gray #2 <input type="checkbox"/> Gray #3 | | | | | |
| Note: If polycarbonate is not available Optilite will be furnished | | | Specify Color: <input type="checkbox"/> Rose #1 <input type="checkbox"/> Rose #2 | | | | | |
| Frame Style | | Frame Color | | Temple Length | | | | |
| Eye Size | Bridge Size | Bridge Style | Sideshields | Case | | | | |
| | | <input type="checkbox"/> UNIFIT <input type="checkbox"/> ADJ. PADS | <input type="checkbox"/> PERMANENT FLATFOLD <input type="checkbox"/> DETACHABLE FLATFOLD | | | | | |
| Sphere | Cyl. | Axis | Prism | Base | Dec. (In-Out) | PD | | |
| Distance | R | | | | | Far | Near | |
| | L | | | | | | | |
| Near | R | | | | | | | |
| | L | | | | | | | |
| CO-PAY EMPLOYEE PERSONAL CREDIT CARD | | | | | | BIFOCALS | TRIFOCALS | DOUBLE SEGMENT BIFOCALS |
| () VISA () MASTERCARD | | | | | | FLAT TOP | FLAT TOP | FLAT TOP |
| Expiration Date _____ | | | | | | <input type="checkbox"/> 25 <input type="checkbox"/> 28 <input type="checkbox"/> 35 | <input type="checkbox"/> 7 x 25 <input type="checkbox"/> 8 x 28 <input type="checkbox"/> 8 x 35 | |
| Card Number _____ | | | | | | FULL WIDTH | FULL WIDTH | FULL WIDTH |
| Name on Card _____ | | | | | | | | |
| | | | | | | PROGRESSIVE | <input type="checkbox"/> Standard <input type="checkbox"/> Sola VIP <input type="checkbox"/> Vanlux Comfort | |

TO THE OPHTHALMIC PROFESSIONS: This patient's employment with his company requires that he wear eye protection. In completing the Rx protective eyewear form, please consider the patient's job visual requirements. Be sure to indicate the delivery point for dispensing and verification. Also supply (or arrange to supply) complete frame measurements.
After completion, please detach and retain the professional copy and return the balance of the forms in the set to the patient to deliver to his company. Your assistance and cooperation is appreciated.

OFFICE NAME (please print) _____ DATE _____

REFRACTIONIST SIGNATURE _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

| | | |
|-------------------------------------|------------|-----------|
| CUSTOMER I.D. 742672-100- | NBR AMT | Rx NUMBER |
|-------------------------------------|------------|-----------|