



1006 First Street, Napa, CA 94559
707 254-2020 www.the-eyeworks.com

Got Vision Benefits Plan Form

Date: _____

Name of Business or Family: _____

Address: _____ City: _____ Zip: _____

Telephone: _____ Email: _____

Name of Owner / Manager / Responsible Person or Head of Household:

Number of Employees or Family members participating in the Vision Benefit Plan: _____

Name: _____ Email: _____

Name: _____ Email: _____

Name: _____ Email: _____

Name: _____ Email: _____

Name: _____ Email: _____

Name: _____ Email: _____

Name: _____ Email: _____

Name: _____ Email: _____

We agree to participate in the Vision Benefit Plan with The Eye Works Optometry.

Date: _____ Owner/Mgrs. Responsible Person's Signature: _____

There must be a minimum of four participants to be eligible to participate in the "Got Vision Benefits Plan." This is The Eye Works Optometry's Discount Plan to assist those who do not have vision insurance coverage. Good for business and families of four or more.