

Davis Vision Enrollment Application

Employee (Member) Information (Please Print)



Employer/Group Name		Reason For Application: <input type="radio"/> Addition <input type="radio"/> Reinstate <input type="radio"/> Termination <input type="radio"/> Change <input type="radio"/> COBRA <input type="radio"/> Waive Coverage			Check Type of Coverage: Employee Only <input type="radio"/> Employee and Spouse or Domestic Partner <input type="radio"/> Family <input type="radio"/> Employee & Child <input type="radio"/> Employee & Children <input type="radio"/>		
Employee (Member) First Name / Middle Initial / Last Name							
Mailing Address			City	State	Zip code		
Employee (Member) Identification Number		Effective Date Month Day Year		Employee Status <input type="radio"/> Active <input type="radio"/> Hourly <input type="radio"/> Salary <input type="radio"/> Retired (Date) _____			
Employee Phone Number				Employee Hire Date Month Day Year			
To be completed by Account Administrator or Human Resources representative only: Group Number _____ Payroll Code _____ Subgroup Code _____ Plan Code _____							

Please indicate the change(s) that you need to make to your record:

<input type="radio"/> Change of Name	<input type="radio"/> Change Birthdate	<input type="radio"/> Change Report Code	<input type="radio"/> Change in Group Number	<input type="radio"/> Change Enrollment Status to:	<input type="radio"/> Employee/Children	<input type="radio"/> Employee and Child
<input type="radio"/> Change of Address	<input type="radio"/> Change Effective Date	Existing _____	Existing _____	<input type="radio"/> Employee Only	<input type="radio"/> Employee and Spouse / Domestic Partner	<input type="radio"/> Family
<input type="radio"/> Change of Phone	New _____	New _____	New _____			

Complete If Applicable	First Name / Middle Initial / Last Name	Social Security Number	Change	Effective Date of Change			Sex F/M	Check If		Birth Date*		
				MM	DD	YY		Student Over 19	Disabled	MM	DD	YY
				Self			<input type="radio"/> Add <input type="radio"/> Term					
<input type="radio"/> Spouse <input type="radio"/> Dom. Part			<input type="radio"/> Add <input type="radio"/> Term									
<input type="radio"/> Child <input type="radio"/> Other			<input type="radio"/> Add <input type="radio"/> Term									
<input type="radio"/> Child <input type="radio"/> Other			<input type="radio"/> Add <input type="radio"/> Term									
<input type="radio"/> Child <input type="radio"/> Other			<input type="radio"/> Add <input type="radio"/> Term									
<input type="radio"/> Child <input type="radio"/> Other			<input type="radio"/> Add <input type="radio"/> Term									
<input type="radio"/> Child <input type="radio"/> Other			<input type="radio"/> Add <input type="radio"/> Term									
<input type="radio"/> Child <input type="radio"/> Other			<input type="radio"/> Add <input type="radio"/> Term									

“I certify that this enrollment information is true and correct.”

* Required for all members/dependents

Member/Employee Signature _____

Date _____