

Davis Vision Enrollment Application

Employee (Member) Information (Please Print)



Employer/Group Name			Reason For Application: <input type="checkbox"/> Addition <input type="checkbox"/> Reinstatement <input type="checkbox"/> Termination <input type="checkbox"/> Change <input type="checkbox"/> COBRA <input type="checkbox"/> Waive Coverage			Check Type of Coverage: Employee Only <input type="checkbox"/> Employee and Spouse or Domestic Partner <input type="checkbox"/> Family <input type="checkbox"/> Employee & Child <input type="checkbox"/> Employee & Children <input type="checkbox"/>		
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="checkbox"/> Active <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> 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="checkbox"/> Change of Name	<input type="checkbox"/> Change Birthdate	<input type="checkbox"/> Change Report Code	<input type="checkbox"/> Change in Group	<input type="checkbox"/> Change Enrollment	<input type="checkbox"/> Employee/Children	<input type="checkbox"/> Employee and Child
<input type="checkbox"/> Change of Address	<input type="checkbox"/> Change Effective Date	Existing _____	Number _____	Status to:	<input type="checkbox"/> Employee and	<input type="checkbox"/> Family
<input type="checkbox"/> Change of Phone	New _____	Existing _____	New _____	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Spouse / Domestic Partner	

Complete If Applicable Self	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
			<input type="checkbox"/> Add <input type="checkbox"/> Term									
<input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Part			<input type="checkbox"/> Add <input type="checkbox"/> Term									
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term									
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term									
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term									
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term									
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term									
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term									

"I certify that this enrollment information is true and correct."

* Required for all members/dependents

Member/Employee Signature

Date