Davis Vision Enrollment Application

DAVIS VISION
EYECARE REFRAMED℠

Employee (Member) Information (Please Print)

Employer/Group Name	Reason for Application: ☐Addition ☐Reinstate ☐Termination ☐Change ☐COBRA ☐Waive Coverage
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: ☐Active ☐Hourly ☐Salaried ☐Retired (Date) _____	
Employee Phone Number / Employee Hire Date: Month / Day / Year	

Check Type of Coverage:	
Employee Only	☐
Employee and Spouse or Domestic Partner	☐
Family	☐
Employee & Child	☐
Employee & Children	☐
To be complete 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:

☐Change of Name ☐Change of Address ☐Change of Phone	☐Change of Birthdate ☐Change of Effective Date	☐Change of Report Code Existing _____ New _____	☐Change in Group # Existing _____ New _____	☐Change of Enrollment Status to: ☐Employee Only ☐Employee/Children ☐Employee and Spouse/ Domestic Partner ☐Family ☐Employee and Child

Complete If Applicable	First Name/Middle Initial/Last Name	Social Security Number	Change	Effective Date of Change			Sex	Check If		Birth Date *		
				MM	DD	YY	M/F	Student over 19	Disabled	MM	DD	YY
Self			☐Add ☐Term									
☐Spouse ☐Dom. Partner			☐Add ☐Term									
☐Child ☐Other			☐Add ☐Term									
☐Child ☐Other			☐Add ☐Term									
☐Child ☐Other			☐Add ☐Term									

I certify that this enrollment information is true and correct

*Required for all members and dependents

Member/Employee Signature _____ Date _____

Updated 8/4/14