

Davis Vision Enrollment Application



Employee Information (Please Print)

Employer Name/Group Number		Reason For Application:				Check Type of Coverage:			
		<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				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		Employee Status				
			Month	Day	Year	<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:						_____			
_____ Marcellus CSD _____						Group Number			
Payroll Code						_____			
_____001_____						_____XFY_____			
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 Spouse / Domestic Partner	<input type="checkbox"/> Family
<input type="checkbox"/> Change of Phone	New _____	New _____	New _____	<input type="checkbox"/> Employee Only		

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		F/M	Student Over 19	Disabled	MM	DD
				Self			<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									

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

_____ Member/Employee Signature

_____ Date

* Required for all Employee/dependents