Davis Vision Enrollment Application

DAVIS VISION
EYECARE REFRAMED℠

Employee Information (Please Print)

Employer Name/Group Number

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 ☐ Salary
☐ 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 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:

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

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

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

_____ Member/Employee Signature

_____ Date

*** Required for all Employee/dependents**