

Davis Vision Enrollment Application

Subscriber Information (Please Print)

Employer Name/Group Number		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: Subscriber Only <input type="checkbox"/> Subscriber and Spouse or Domestic Partner <input type="checkbox"/> Family <input type="checkbox"/> Subscriber & Child <input type="checkbox"/> Subscriber & Children <input type="checkbox"/>		
Subscriber (Member) First Name / Middle Initial / Last Name							
Mailing Address			City	State	Zip code		
Subscriber (Member) Identification Number		Effective Date Month Day Year		Subscriber Status <input type="checkbox"/> Active <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Retired (Date) _____			
Subscriber Phone Number				Subscriber 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"/> Subscriber/Children	<input type="checkbox"/> Subscriber and Child
<input type="checkbox"/> Change of Address	<input type="checkbox"/> Change Effective Date	Existing _____	Number _____	Status to:	<input type="checkbox"/> Subscriber and	<input type="checkbox"/> Family
<input type="checkbox"/> Change of Phone		New _____	Existing _____	<input type="checkbox"/> Subscriber Only	Spouse / Domestic	
			New _____		Partner	

Complete If Applicable Self	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
							<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 Subscriber/dependents

Member/Subscriber Signature

Date