

Davis Vision Enrollment Application

Employee (Member) Information (Please Print)

OPEN ENROLLMENT

Change to Family



Employer/Group Name Onondaga Cortland Madison BOCES		Reason for Application: <input type="checkbox"/> Addition <input type="checkbox"/> Reinstatement <input type="checkbox"/> Termination <input checked="" type="checkbox"/> Change <input type="checkbox"/> COBRA <input type="checkbox"/> Waive Coverage			
Employee (Member) First Name / Middle Initial / Last Name					
Mailing Address		City	State	Zip Code	
Employee (Member) Social Security #	Effective Date: Month: 01 Day: 01 Year: 21		Employee Status <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried <input type="checkbox"/> Retired (Date) _____		
Employee Phone Number		Employee Hire Date Month: _____ Day: _____ Year: _____			

Check Type of Coverage:			
Employee Only	<input type="checkbox"/>		
Employee & Spouse	<input type="checkbox"/>		
Employee & Child(ren)	<input type="checkbox"/>		
Family	<input type="checkbox"/>		
To be completed by Account Administrator or Human Resources representative only			
Group Number	Z1S		
Payroll Code			
Subgroup Code	0003	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 of Address <input type="checkbox"/> Change of Phone	<input type="checkbox"/> Change of Birthdate <input type="checkbox"/> Change of Effective Date	<input type="checkbox"/> Change of Report Code Existing _____ New _____	<input type="checkbox"/> Change in Group # Existing _____ New _____	<input checked="" type="checkbox"/> Change of Enrollment Status to: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Family
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Complete If Applicable	First Name/Middle Initial/Last Name	Change	Effective Date of Change			Sex M/F	Check If		Birth Date *		
			MM	DD	YY		Student over 19	Disabled	MM	DD	YY
Self		<input type="checkbox"/> Add <input type="checkbox"/> Term									
<input type="checkbox"/> Spouse		<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									

Please return completed form to:
 Davis Vision CDM – Manual Eligibility
 Fax: 1-800-783-9046

Member/Employee Signature

Date

I certify that this enrollment information is true and correct
 *Required for all members and dependents