Davis Vision Enrollment Application

OPEN ENROLLMENT

DAVIS VISION
EYECARE REFRAMED℠

Employee (Member) Information (Please Print)

Employer/Group Name	Reason for Application:
Onondaga Cortland Madison BOCES	☒ Addition ☐ Reinstate ☐ Termination ☐ Change ☐ COBRA ☐ Waive Coverage

Employee (Member) First Name / Middle Initial / Last Name

Mailing Address	City	State	Zip Code

Employee (Member) Social Security #	Effective Date: Month	Day	Year	Employee Status
	01	01	21	☒ Active ☐ Hourly ☐ Salaried ☐ Retired (Date) _____

Employee Phone Number	Employee Hire Date: Month	Day	Year

Check Type of Coverage:

Employee Only	☐
Employee & Spouse	☐
Employee & Child(ren)	☐
Family	☐

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:

☐ 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/Child(ren) ☐ Employee and Spouse ☐ Family

Complete If Applicable	First Name/Middle Initial/Last Name	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		☐ Add ☐ Term									
☐ Child ☐ Other		☐ Add ☐ Term									
☐ Child ☐ Other		☐ Add ☐ Term									
☐ Child ☐ Other		☐ Add ☐ 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

Updated 8/4/14