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	[X] Addition [ ] Reinstate [ ] Termination [ ] Change [ ] COBRA [ ] Waive Coverage	

Check Type of Coverage:

Employee Only	[ ]
Employee & Spouse	[ ]
Employee & Child(ren)	[ ]
Family	[ ]

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

Mailing Address	City	State	Zip Code

To be completed by Account Administrator or Human Resources representative only

Employee (Member) Social Security #	Effective Date: Month **01** Day **01** Year **26**	Employee Status [X] Active [ ] Hourly [ ] Salaried [ ] Retired (Date) _____

Group Number	Z1S
Payroll Code	
Subgroup Code	Plan Code

Employee Phone Number	Employee Hire Date Month Day Year

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

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Complete If Applicable	First Name/Middle Initial/Last Name	Change	Effective Date of Change MM	DD	YY	Sex M/F	Student over 19	Disabled	Birth Date MM	DD	YY
Self		[ ] Add [ ] Term									
[ ] Spouse		[ ] Add [ ] Term									
[ ] Child [ ] Other		[ ] Add [ ] Term									
[ ] Child [ ] Other		[ ] Add [ ] Term									
[ ] Child [ ] Other		[ ] Add [ ] Term									

[X] _____   _____
Member/Employee Signature   Date

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

Updated 8/4/14