Davis Vision Enrollment Application

DAVIS VISION
EYECARE REFRAMED℠

Employee (Member) Information (Please Print)

Employer/Group Name	Reason for Application:
TOWN OF MANSFIELD	☐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 ☐Salaried ☐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 complete 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 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/Children ☐Employee and Spouse/ Domestic Partner ☐Family ☐Employee and Child

Complete If Applicable	First Name/Middle Initial/Last Name	Social Security Number	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 ☐Dom. Partner			☐Add ☐Term									
☐Child ☐Other			☐Add ☐Term									
☐Child ☐Other			☐Add ☐Term									
☐Child ☐Other			☐Add ☐Term									

Member/Employee Signature

Date

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

Updated 8/4/14

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