DAVIS VISION
THE EYECARE ADVANTAGE
www.davisvision.com

Vision Care Enrollment Form

Please return completed enrollment form to your Human Resources department

Instructions:

1. You must enroll using this form before you or a family member can begin to use this vision benefit. No enrollment fee is required. Premiums will be collected through payroll deductions, if applicable. Should you choose to waive coverage at this time you may not enroll until the next formal enrollment period.
2. For new or changed enrollments, you must complete all information requested.
3. To enroll a dependent, include their name, date of birth, and relationship. For relationship, use the following codes: **W=Wife, H=Husband, S=Son, D=Daughter, P=Domestic Partner (if applicable).**
4. You **may** or **may not**:
   - be able to be covered as both a member and as a dependent of a member, if both you and your spouse are employed by the same company or bargaining unit.
   - be required to enroll for a specified minimum time period.

   Please verify this information with your benefit office.

****PLEASE NOTE: All information below must be completed in order to process your enrollment.****

Is this the first time you have enrolled in the Vision Care Plan or are you changing an existing enrollment record?

☐ **New Enrollment** ☐ **Change** Reason for change _____

Member/Employee Information:

Member ID *: _____ ** Your Member Identification is the number by which the company that sponsors your vision care benefits identifies you.*

First Name: _____ Last Name: _____

Gender: ☐ **Female** ☐ **Male** Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Daytime Phone Number: ( ) _____

Is the address listed above new? ☐ **Yes** ☐ **No**

List All Eligible Dependents Below*

☆A/D/C	Last Name (if different from member)	First	M.I.	Rel.	Date of Birth	M/F

*Please Note: If your dependent(s) are already on file you do not need to provide their information again - unless it is changing.

☆ A=Add D=Delete C=Change

"I certify that this enrollment information is true and correct."

_____ _____

Member/Employee Signature Date