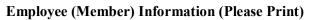
Davis Vision Enrollment Application





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Employer/Group Name TOWN OF MANSFIELD							Reason for Application:						Check Type of Coverage: Employee Only						
							Addition Reinstate Termination												
							Change COBRA Waive Coverage						Employee and Spouse or Domestic Partner						
Employee (Member) First Name / Middle Initial / Last Name													Family						
													Employee & C	Child					
													Employee & Children						
Mailing Address							City	State		Zip Code									
													To be complet	e by Account	Administ	rator or I	Human		
E 1 Of 1 M CC C N 1							F		- Ct. t				Resources representative only						
Employee (Member) Identification Number					Vaan		oyee Status			-			-						
Month Day Y						<u>Year</u>	☐Active	Salaried			Group Number								
											-	Group Numbe	1						
Employee Phone Number							Retired (Date) Employee Hire Date						Payroll Code						
Employee I none Number							Month	<u>Da</u>		Year Year		-	Tayron Code						
							Month	<u> </u>	<u>.,</u>				Subgroup Cod	e.	Plan	Code			
													Suegroup cou			0000			
Please indicate the change(s) that you need to make to your record:																			
Theast indicate the change(s) that you need to make to your record.																			
_																			
□ Change of Name □ Change of Birthdate □ Change of Rep □ Change of Effective □ Code			ort	Change	in Group #	L				Change of Enrollment Status to:									
			/e				Existing						Employee/Children						
Address	Date	Existing				_	New		Employee Only			_							
☐Change of Phone	New				_			Employee and Spouse/ Do			Domest	omestic Partner Family							
									☐Employee and Child										
									Effective Date of			Sex	Check If		Birth Date *				
Complete If Applicable		First Name/Middle Initial/Last Name			l/Last Name		l Security	Change		Change	e	56.2			Dir til Dutt		 		
					Ni	umber		MM	DD	YY	M/F	Student	Disabled	MM	DD	YY			
								□Add					over 19						
Self								Term											
								Add											
☐Spouse ☐Dom. Par	tner							Term											
								Add											
☐Child ☐Other								☐ Add ☐ Term											
											-								
□Child □Other						Add													
							Term	+	+										
☐Child ☐Other							☐Add □Term												
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Member/Employee Signature

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

Please return completed form to:

Davis Vision CDM – Manual Eligibility

Fax: 1-800-783-9046

Date

Updated 8/4/14