



# Davis Vision Enrollment Application

Employee (Member) Information (Please Print)

Employer/Group Name <b>TOWN OF LINCOLN</b>		Reason for Application: <input type="checkbox"/> Addition <input type="checkbox"/> Reinstatement <input type="checkbox"/> Change <input type="checkbox"/> COBRA <input type="checkbox"/> Termination		
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 <input type="checkbox"/> Active <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Retired (Date)	
Employee Phone Number		Employee Hire Date Month   Day   Year		

Check Type of Coverage:	
Employee Only	<input type="checkbox"/>
Employee and Spouse or Domestic Partner	<input type="checkbox"/>
Family	<input type="checkbox"/>
Employee and Child	<input type="checkbox"/>
Employee and Children	<input type="checkbox"/>

To be completed by Account Administrator or Human Resources representative only:	
Group Number	
Payroll Code	
Branch Code	

**Please indicate the change(s) that you need to make to your record:**

<input type="checkbox"/> Change of Name	<input type="checkbox"/> Change Birthdate	<input type="checkbox"/> Change Report Code	<input type="checkbox"/> Change in Group	<input type="checkbox"/> Change Enrollment Status to:	<input type="checkbox"/> Employee and Spouse/Domestic Partner
<input type="checkbox"/> Change of Address	<input type="checkbox"/> Change Effective Date	Existing	Number Existing	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee and Child
<input type="checkbox"/> Change of Phone		New	New	<input type="checkbox"/> Employee/Children	<input type="checkbox"/> Family

Complete (if applicable)	First Name/Middle Initial/Last Name	Social Security Number	Change	Effective Date of Change			Sex F/M	Check if		Birth Date*		
				MM	DD	YY		Student Over 19	Disabled	MM	DD	YY
<input type="checkbox"/> Self			<input type="checkbox"/> Add <input type="checkbox"/> Term					<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Part.			<input type="checkbox"/> Add <input type="checkbox"/> Term					<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term					<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term					<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term					<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term					<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term					<input type="checkbox"/>	<input type="checkbox"/>			

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

\* Required for all members/dependents

Type Name Of Member/Employee Completing Form

Date