INDIVIDUAL ENROLLMENT/CHANGE FORM

FOR VISION COVERAGE
(Please Print or Type)

EMPLOYER (GROUP) NAME Davison Community Schools	GROUP NO. 51718 0001 01 ☐ CFMT 51718 0001 99 ☐ CFMT Cobra 51718 0002 01 ☐ DEA 51718 0002 99 ☐ DEA Cobra 51718 0003 01 ☐ DESA 51718 0003 99 ☐ DESA Cobra 51718 0004 01 ☐ Non Union 51718 0004 99 ☐ Non Union Cobra

EMPLOYEE LAST NAME	FIRST	MI	DATE OF BIRTH

STREET ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY NUMBER	GENDER	CONTRACT TYPE REQUESTED
__ __	☐ Male ☐ Female	☐ Single (S) ☐ Employee + 1 (L) ☐ Family [Employee + 2 or more] (F)

EFFECTIVE DATE OF COVERAGE *OR* CHANGE	DATE OF HIRE

COMPLETE THE FOLLOWING FOR ALL FAMILY MEMBERS FOR WHOM YOU ARE REQUESTING COVERAGE

PLEASE CHECK THE APPROPRIATE ACTION CODES FOR CHANGES

THIS CHANGE IS FOR: ☐ EMPLOYEE ☐ SPOUSE ☐ DEPENDENT(S)

TYPE OF CHANGE: ☐ NEW ENROLLMENT ☐ CHANGE OF ADDRESS ☐ NAME CHANGE ☐ REINSTATEMENT ☐ CHANGE TO COBRA

☐ ISSUE CARD ☐ CANCEL COVERAGE ☐ NAME CHANGE, FORMERLY _____

LAST NAME	FIRST NAME	INITIAL	M / F	DATE OF BIRTH	STUDENT (Y/N)
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I HEREBY APPLY FOR ENROLLMENT FOR VISION COVERAGE.

EMPLOYEE SIGNATURE: **X** _____ DATE: _____

EMPLOYER SIGNATURE: **X** _____ DATE: _____

www.e-nva.com

NATIONAL VISION ADMINISTRATORS, L.L.C.
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