



INDIVIDUAL ENROLLMENT/CHANGE FORM

FOR VISION COVERAGE
(Please Print or Type)

| | | | |
|--|--|---|---------------|
| EMPLOYER (GROUP) NAME Davison Community Schools | | GROUP NO. 51718 0001 01 <input type="checkbox"/> CFMT 51718 0001 99 <input type="checkbox"/> CFMT Cobra 51718 0002 01 <input type="checkbox"/> DEA 51718 0002 99 <input type="checkbox"/> DEA Cobra 51718 0003 01 <input type="checkbox"/> DESA 51718 0003 99 <input type="checkbox"/> DESA Cobra 51718 0004 01 <input type="checkbox"/> Non Union 51718 0004 99 <input type="checkbox"/> Non Union Cobra | |
| EMPLOYEE LAST NAME | FIRST | MI | DATE OF BIRTH |
| STREET ADDRESS | | CITY | STATE ZIP |
| SOCIAL SECURITY NUMBER | GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female | CONTRACT TYPE REQUESTED <input type="checkbox"/> Single (S) <input type="checkbox"/> Employee + 1 (L) <input type="checkbox"/> 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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