# DAVIS VISION ENROLLMENT & CHANGE FORM

***NOTE****: Return your completed form to your Local Benefits Administrator within 30 calendar days of the date of enrollment, a life event, date of any change(s). Failure to do so may result in a loss of coverage.*

Reason for Completing This Form: ☐ Open Enrollment ☐ New Enrollment ☐ Status Change ☐ Reinstatement ☐ Address Change
☐ Dependent Enrollment ☐ Marital/Dependent Change Status

Effective Date: ____/_____/______

Type of Change:

☐ Add Dependent(s) Effective Date _____/_____/_____ ☐ Waive Coverage
☐ Marital Status Change Effective Date _____/_____/_____
☐ Cancel Employee Effective Date _____/_____/_____
☐ Cancel Dependent(s) Effective Date _____/_____/_____

**Member Information:**
(PLEASE PRINT CLEARLY)

Last Name____________________________________ First Name ________________________________ MI ____ Social Security No.______________________

Date of Birth___/____/_____ Gender ☐ Male ☐ Female Home Address ________________________________________________ Apt. No. ____________

City ________________________________________________ State _____ Zip _________ Home Phone ___________________ Work Phone _______________

Date of Hire____/____/____ Occupation________________________________________ Covered by Collective Bargaining Agreement: ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married (Marriage Date) ____/____/____ ☐ Divorced ☐ Widowed

☐ I am a Full Time Employee Scheduled to regularly work 30 or more hours per week *(20 hours for FCT Bargaining Lay Faculty Members)*

**Employer Information:**

Institution Name ____________________________________________________________ Inst./Dept. #. ______________/_______________ Claims Division Code __________

Street Address___________________________________________________________________________________ City_____________________________________________

State _______ Zip _________________ Telephone ________________________________

<u>Type of Election for the 2020 Plan Year & *Annual Costs*</u>: ☐ Single $60.00 ☐ Two Person $120.00 ☐ Family $180.00 ☐ Waive Coverage

<u>Dependent Information</u>

List below your name and the name(s) of eligible dependents(s) to be covered, your spouse and dependent children. A child will be considered a dependent to the end of the month in which they turn age 26 as long as he/she is unmarried, and cannot be insured by or eligible for vision insurance through his/her own employer.

| Name of Dependent | Sex *(M/F)* | Relationship To Employee | Date of Birth *Mo./Day/Yr.* | Social Security # |
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Employee Affirmation:

My signature below affirms eligibility for vision coverage and authorization to deduct elected contribution from my paycheck. All information is complete and true to the best of my knowledge.

Employee/Participant Signature *(Required)*: ______________________________ Date: _____/_____/______

Employee/Participant Print Name *(Required)*: ______________________________

Employer's Signature *(Required)*: ______________________________ Date: _____/______/______

Employer Print Name *(Required)*: ______________________________

<u>Note</u>: Any person who knowingly and with intent to defraud, submit an application for vision benefits or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent act, which subjects such person to civil penalties.

<u>Administrators:</u> Send completed form to Employees Benefit Connections at ebc@archny.org or fax to EBC 1.212.644.0690 – for any questions or further assistance, please call 1.646.794-3060

<u>Administrators:</u> *If you are a Regional Employee, your completed form must be sent to your HR Coordinator.*

December 2019