ARCHDIOCESE OF NEW YORK

DavisVision

For More Information, Please
Visit www.davisvision.com

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 ☐ Qualified Life Event _____

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** _____ **Email Address:** _____

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** _____

Type of Election for the 2022 Plan Year & *Annual Costs*: ☐ **Single $60.00** ☐ **Two Person $120.00** ☐ **Family $180.00** ☐ **Waive Coverage**

Dependent Information

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 #
		SELF		

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)*: _____

Note: 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.

Administrators: Please send completed form to Employees Benefit Connections at ebc@archny.org – for any questions or further assistance, please call 1.646.794-3060

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