

Davis Vision Enrollment Application

Employee (Member) Information (Please Print)

Employer/Group Name NEW YORK CITY DEPUTY SHERIFF BENEVOLENT ASSOCIATION		Reason for Application: <input checked="" type="checkbox"/> Addition <input type="checkbox"/> Reinstatement <input type="checkbox"/> Termination <input type="checkbox"/> Change <input type="checkbox"/> COBRA <input type="checkbox"/> Waive Coverage			
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 checked="" type="checkbox"/> Active <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried <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 & Child			<input type="checkbox"/>
Employee & Children			<input type="checkbox"/>
To be complete by Account Administrator or Human Resources representative only			
Group Number	SD060		
Payroll Code			
Subgroup Code	060	Plan Code	1FU

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

<input type="checkbox"/> Change of Name <input type="checkbox"/> Change of Address <input type="checkbox"/> Change of Phone	<input type="checkbox"/> Change of Birthdate <input type="checkbox"/> Change of Effective Date	<input type="checkbox"/> Change of Report Code Existing _____ New _____	<input type="checkbox"/> Change in Group # Existing _____ New _____	<input type="checkbox"/> Change of Enrollment Status to: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee and Spouse/ Domestic Partner <input type="checkbox"/> Employee and Child	<input type="checkbox"/> Employee/Children <input type="checkbox"/> Family
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Complete If Applicable	First Name/Middle Initial/Last Name	Social Security Number	Change	Effective Date of Change			Sex M/F	Check If		Birth Date *		
				MM	DD	YY		Student over 19	Disabled	MM	DD	YY
Self			<input type="checkbox"/> Add <input type="checkbox"/> Term									
<input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Partner			<input type="checkbox"/> Add <input type="checkbox"/> Term									
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term									
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term									
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term									

I certify that this enrollment information is true and correct

*Required for all members and dependents

Member/Employee Signature

Date