

Davis Vision Enrollment Application

University of Virginia



Employee (Member) Information (Please Print)

Employer/Group Name <input type="checkbox"/> University <input type="checkbox"/> Medical Center		Reason For Application: <input type="checkbox"/> Addition <input type="checkbox"/> Reinstatement <input type="checkbox"/> Termination <input type="checkbox"/> Change <input type="checkbox"/> COBRA		Check Type of Coverage: Employee Only <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Family <input type="checkbox"/> Employee & Child <input type="checkbox"/>	
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 type="checkbox"/> Active <input type="checkbox"/> COBRA	
Employee Phone Number			Employee Email		

To be completed by Account Administrator or Human Resources representative only:

Group Number _____

Payroll Code _____

Branch Code _____

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

<input type="checkbox"/> Change of Name	<input type="checkbox"/> Change Birthdate	<input type="checkbox"/> Change Report Code	<input type="checkbox"/> Change in Group Number	<input type="checkbox"/> Change Enrollment Status to:	<input type="checkbox"/> Employee and Spouse	<input type="checkbox"/> Family
<input type="checkbox"/> Change of Address	<input type="checkbox"/> Change Effective Date	Existing _____	Existing _____	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee and Child	
<input type="checkbox"/> Change of Phone		New _____	New _____			

Complete If Applicable Self	First Name / Middle Initial / Last Name	Social Security Number	Change	Effective Date of Change			Sex	Check If		Birth Date*		
				MM	DD	YY		F/M	Student Over 19	Disabled	MM	DD
				<input type="checkbox"/> Add <input type="checkbox"/> Term								
<input type="checkbox"/> Spouse			<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									
<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/dependents. Eligibility for dependent enrollment in the vision plan mirrors that used for the University of Virginia Health Plan.

Member/Employee Signature

Date