Davis Vision Enrollment Application

Employee Information (Please Print)

Employer Name/Group Number

GENESEE AREA HEALTHCARE PLAN

Reason For Application:

☐ Addition ☐ Reinstate ☐ Termination
☐ Change ☐ COBRA ☐ Waive Coverage

Employee (Member) First Name / Middle Initial / Last Name

Mailing Address | City | State | Zip code

Employee (Member) Identification Number if know

Effective Date: Month | Day | Year

Employee Status: ☐ Active ☐ Hourly ☐ Salary ☐ Retired (Date) ______________

Employee Phone Number

Employee Hire Date: Month | Day | Year

Check Type of Coverage:

- Employee Only ☐
- Employee and Spouse ☐
- Family ☐
- Employee & Child ☐
- Employee & Children ☐

To be completed by Account Administrator only:

10P100000769
Group Number

N/A
Payroll Code

001
Subgroup Code | Plan Code

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

☐ Change of Name
☐ Change of Address
☐ Change of Phone
☐ Change Birthdate
☐ Change Effective Date
☐ Change Report Code
Existing ________
New ____________
☐ Change in Group No.
Existing ________
New ____________
☐ Change Enrollment Status to:
☐ Employee Only
☐ Employee/Children
☐ Employee and Spouse
☐ Employee and Child
☐ Family

Complete If Applicable	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	YY
Self			☐ Add ☐ Term									
☐ Spouse			☐ Add ☐ Term									
☐ Child ☐ Other			☐ Add ☐ Term									
☐ Child ☐ Other			☐ Add ☐ Term									
☐ Child ☐ Other			☐ Add ☐ Term									
☐ Child ☐ Other			☐ Add ☐ Term									
☐ Child ☐ Other			☐ Add ☐ Term									

"I certify that this enrollment information is true and correct."

_______________________________ Member/Employee Signature

__________ Date

*** Required for all Employee/dependents**

Please send the completed form via fax or email to your corresponding district clerk.

EF00069 7/25/18