Davis Vision Enrollment Application

DAVIS VISION
EYECARE REFRAMED℠

Employee (Member) Information (Please Print)

Employer/Group Name	Reason for Application:
AFSCME Nevada Retirees Chapter 4041	☐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 *	Effective Date: Month	Day	Year	Employee Status
	10	01	2017	☐Active ☐Hourly ☐Salaried ☐Retired (Date) _____

Employee Phone Number	Employee Hire Date Month	Day	Year

Please indicate the change(s) that you need to make to your record:
(* Items with an asterisk are required fields)

Check Type of Coverage:	
Employee Only	☐
Employee and Spouse or Domestic Partner	☐
Family	☐
Employee & Children	☐

To be complete by Account Administrator or Human Resources representative only

Group Number	**YZ5**		
Payroll Code			
Subgroup Code	**001**	Plan Code	**01X**
Plan Description	☒ **Premier Plan**		

☐Change of Name ☐Change of Address ☐Change of Phone	☐Change of Birthdate ☐Change of Effective Date	☐Change of Report Code Existing _____ New _____	☐Change in Group # Existing _____ New _____

☐Change of Enrollment Status to:

☐Employee Only ☐Employee/Children
☐Employee and Spouse/ Domestic Partner ☐Family
☐Employee and Child

Complete All Sections	First Name/Middle Initial/Last Name	Social Security Number *	Change	Effective Date of Change *			Sex	Check If		Birth Date *		
				MM	DD	YY	M/F	Student over 19	Disabled	MM	DD	YY
Self			☐Add ☐Term									
☐Spouse ☐Dom. Partner			☐Add ☐Term									
☐Child ☐Other			☐Add ☐Term									
☐Child ☐Other			☐Add ☐Term									
☐Child ☐Other			☐Add ☐Term									

Please return completed form to:
AFSCME NV Retirees Chapter 4041
P.O. Box 662
Carson City, NV 89702

Member/Employee Signature *

Date

I certify that this enrollment information is true and correct
*Required for all members and dependents

YZ5-TUSD202