

New Enrollee     Termination     Change of Status     Change of Address

SECTION I: XB7 GROUP INFORMATION		
Group Name	Group Number	Effective Date

SECTION II: EMPLOYEE INFORMATION			
Last Name:	First Name:	Middle Initial	
Social Security Number	Date of Birth mm/dd/yyyy	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address	City	State	ZIP Code

SECTION III: DEPENDENT INFORMATION		
Spouse Name (Last, First, M.I.) (if applying for spousal coverage)	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

Other Eligible Dependent Information (if additional space is needed, please attached a separate sheet of paper)			
Name	Date of Birth	Gender	Relationship
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	

SECTION IV: VISION COVERAGE SELECTIONS	
<b>Coverage Choice:</b> (check one coverage only)	
<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family
<b>Plan Choice:</b> (Fill in plan name in space below)	

I represent that the information provided above is true and correct to the best of my knowledge and belief. For those coverages I have declined, I understand that I can terminate or change previously elected coverage only during an employer-sponsored open enrollment period or on a qualifying event. If the plan provides that any contributions be made by me, I authorize my employer to deduct them from my pay.

**In Florida, any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**TERMINATION OF COVERAGE:**

I wish to terminate my Vision coverage. I understand that I can terminate or change previously elected coverage only during an employer-sponsored open enrollment period or on a qualifying event.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

Please return completed form via secure email to: [FloridaVision@davisvision.com](mailto:FloridaVision@davisvision.com) or Fax: 1-800-783-9046 or mail to: Davis Vision Manual Enrollment, Attention: Florida Vision, P.O. Box 1501 Latham, NY 12110