Administered by:

DAVISVISION
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Vision Benefits Employee Enrollment Form

☐ New Enrollee ☐ Termination ☐ Change of Status ☐ Change of Address

SECTION I: GROUP INFORMATION

Group Name			Group Number
Town of Norton			X06-540432
Division	Class	Department	Effective Date

SECTION II: EMPLOYEE INFORMATION

Employee Name (Last, First, M.I.)	Social Security Number	Date of Birth	Gender ☐ Male ☐ Female
Address	City	State	ZIP Code

Do you have eligible dependent children? ☐ Yes ☐ No

SECTION III: DEPENDENT INFORMATION

Spouse Name (Last, First, M.I.) *(if applying for spousal coverage)*	Social Security Number	Date of Birth	Gender ☐ Male ☐ Female

Other Eligible Dependent Information *(if additional space is needed, please attached a separate sheet of paper)*

Name	Date of Birth	Gender	Relationship
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	

SECTION IV: VISION COVERAGE SELECTIONS

Coverage Choice *(check one coverage only)*:

☐ Employee Only	☐ Employee+Spouse	☐ Employee+Child(ren)	☐ Employee+Family
$5.59/mo	$10.07/mo	$10.63/mo	$16.78/mo

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.

Employee Signature _____ Date _____

REFUSAL OF GROUP COVERAGE:
I have been offered and decline to purchase the Vision coverage(s) at this time. I understand that in the event I desire such insurance at a later date, I may be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

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 to:
Davis Vision
Phone: 888-543-6553 Fax:412-544-1160
Email: groupbilling@hminsurancegroup.com

Underwritten by HM Life Insurance Company

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