

Change of Name
(Please print, in ink)

For Local Use Only
Group No.:

Name (Last, First, Middle Initial) Social Security Number

Home Address City State Zip

Benefit Fund or Employer Name

Date of Birth Home Phone Work Phone

Check if new address

Change of Marital Status/Name

I have been married (complete reverse to add spouse to coverage) Date: _____

I have been divorced or legally separated (complete reverse to remove spouse from coverage) Date: _____

New Name: _____ Former Name: _____

Signature (Form must be signed.) Date

To change your dependent coverage, please complete the reverse side of this card.

Send eligibility changes to: Davis Vision Eligibility Team, P.O. Box 1525, Latham, NY 12110

Printed 9/05 – 1,000

Change of Dependents

Add my spouse

Add my child(ren)

Remove my spouse

Remove my child(ren)

First Name, MI	Last Name (if different)	Relationship	Date of Birth	Full Time Student
		<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son		<input type="checkbox"/> Yes <input type="checkbox"/> No

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