

# Fayette County Public Schools Davis Vision Enrollment Application



## Employee (Member) Information (Please Print)

Employer/Group Name <b>FAYETTE COUNTY PUBLIC SCHOOLS</b>		Reason For Application: <input type="checkbox"/> Open enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Addition <input type="checkbox"/> Reinstatement <input type="checkbox"/> Termination <input type="checkbox"/> Change <input type="checkbox"/> COBRA <input type="checkbox"/> Waive Coverage			Check Type of Coverage: Employee Only <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Employee & Family <input type="checkbox"/>		
Employee (Member) First Name / Middle Initial / Last Name							
Mailing Address			City	State	Zip code		
Employee Number or Social Security Number		Effective Date Month   Day   Year		Employee Status <input type="checkbox"/> Active <input type="checkbox"/> 18 pay <input type="checkbox"/> 24 pay <input type="checkbox"/> Retired (Date) _____			
Employee Phone Number				Employee Hire Date Month   Day   Year			

To be completed by Account Administrator or Human Resources representative only:

FAY -  
Group Number

EE: 4.91 ES: 8.53 EC: 8.97 F: 13.94  
18 Pay

EE: 3.69 ES: 6.40 EC: 6.73 F: 10.46  
24 Pay

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

<input type="checkbox"/> Change of Name	<input type="checkbox"/> Change Birthdate	<input type="checkbox"/> Change in Group Number	<input type="checkbox"/> Change Enrollment Status to:	<input type="checkbox"/> Employee and Spouse	<input type="checkbox"/> Employee and Family
<input type="checkbox"/> Change of Address	<input type="checkbox"/> Change Effective Date	Existing _____	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee and Child(ren)	
<input type="checkbox"/> Change of Phone		New _____			

Complete If Applicable Self	First Name / Middle Initial / Last Name	Social Security Number	Change	Effective Date of Change			Sex F/M	Check If Disabled	Birth Date*		
				MM	DD	YY			MM	DD	YY
				<input type="checkbox"/> Add <input type="checkbox"/> Term							
<input type="checkbox"/> Spouse			<input type="checkbox"/> Add <input type="checkbox"/> Term								
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term								
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term								
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term								
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term								
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term								
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term								

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

\* Required for all members/dependents

WHITE - EMPLOYER

Member/Employee Signature

YELLOW - BIM

PINK - EMPLOYEE

Date