FAX FORMS TO THE ELIGIBILITY TEAM:

FAX# 1-800-783-9046 OR
FAX# (518) 220-6064

DAVIS VISION™
THE EYECARE ADVANTAGE

MEMBER AND/OR DEPENDENT
ADD, CHANGE, TERMINATION,
REINSTATEMENT OR COBRA

DATE: _____

*GROUP NAME: TAL Welfare Trust *GROUP NUMBER: _____

*BENEFIT PLAN CODE: LT

TELEPHONE NUMBER: 631 226 0701 FAX NUMBER: 631 226-0620

MEMBER INFORMATION: BOXED AREAS ARE MANDATORY INFORMATION FOR MEMBER/DEPENDENT ADDITION.

ADD _____ * CHANGE _____ TERMINATE _____ REINSTATE _____ COBRA _____ COMPENSATION _____

*EFFECTIVE: _____ (Date) THRU _____ (Date only if REINSTATE OR COBRA) BRANCH CODE: _____

*COVERAGE TYPE: _____ (If applicable) 1=individual 2=Member & Spouse 3=Family 4=Composite 5=Member & 1 Child 6=Member & Children

*S.S. NO./MEMBER NO: _____ _____ (Modifier) SEX: _____ DATE OF BIRTH: _____

*MEMBER'S LAST NAME: _____ FIRST _____ INITIAL _____

ADDRESS: _____

CITY/ST/ZIP: _____

DEPENDENT INFORMATION:

A/C or D A=Addition C=CHANGE T=TERMINATION
REL. S=SPOUSE C=CHILD O=OTHER
SEX F=FEMALE M=MALE
O/R CODE S=STUDENT H=HANDICAPPED

(Only for children over 19 years old)

A/C or T	*FIRST NAME	INT.	LAST NAME (Only if different than Member)	*REL.	SEX	*DEPENDENT'S SOC. SEC.# & MODIFIER	*BIRTHDATE	O/R CODE	ELIGIBLE THRU DATE

SPECIAL INSTRUCTIONS: _____

PLEASE NOTE: If you wish to change information that exists on our files, the information that has a *to the left is required.