# CARPENTERS' DAVIS VISION

## ENROLLMENT FORM

PLEASE PRINT

| MEMBER INFORMATION | | | | |
|---|---|---|---|---|
| NAME | | | | |
| ADDRESS | | CITY | STATE | ZIP CODE |
| SOCIAL SECURITY NO. | TELEPHONE NO. | | | |

## LIST ELIGIBLE DEPENDENTS TO BE ENROLLED (STARTING WITH MEMBER)

| | NAME | SOCIAL SECURITY NUMBER | BIRTH DATE | CHECK IF STUDENT OVER 18 | CHECK IF DISABLED |
|---|---|---|---|---|---|
| SELF | | | | | |
| SPOUSE | | | | | |
| DEPENDENT | | | | | |
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| DEPENDENT | | | | | |

I certify that the information provided on this form is true to the best of my knowledge. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I understand that this form enrolls those eligible persons listed above in the Vision Plan as described in the agreement between the plan and my Union. I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark's Notice of Privacy Practices is available on Highmark's web site, or from the Highmark Privacy Office.

SIGNATURE & DATE ____________________

### TO BE COMPLETED BY FUND OFFICE ONLY

PAYMENT RECEIVED ____________________

COVERAGE EFFECTIVE DATE ____________________

FILE COMPARISON ____________________