

TO BE COMPLETED BY BENEFITS OFFICE:

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sub Code: \_\_\_\_\_ Client Code: \_\_\_\_\_

G/L Account: \_\_\_\_\_

## Vision Plan Enrollment Form

Organization Name: \_\_\_\_\_

### I. Check the Appropriate Boxes

#### Coverage Desired

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Employee + Family

- New Enrollment
- Change of Status/Address
- Open Enrollment
- COBRA

#### REASON FOR CHANGE IN STATUS

- Termination
- Marriage
- Newborn Child
- Other Insurance
- Move to COBRA
- Death
- Divorce
- Last Name/Address Change
- Adoption/legal custody of child
- Legal custody of parent
- Dependent child married/reached age limit

### II. Employee Information (please print clearly):

Unique Member ID Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Your Name \_\_\_\_\_

(First)

(Middle Initial)

(Last)

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_

### III. List All Eligible Family Members Below (if electing dependent coverage):

	First Name	Last Name	Birth Date	Full Time Student?	Sex
Spouse	_____	_____	____/____/____	not applicable	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F

I agree to continue enrollment in the vision plan for a period of 12 months.

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

I decline to joining the vision plan at this time. Your Signature \_\_\_\_\_ Date \_\_\_\_\_

Spectera, Inc. administers vision benefits underwritten by the following entities: United HealthCare Insurance Company, United HealthCare Insurance Company of New York, Unimerica Insurance Co., Inc., and American General Assurance Company.