TO BE COMPLETED BY GROUP BENEFITS OFFICE:

Effective Date: ____/_______/_______

Group # ________

Plan Variation Vision _______

Reporting Code Vision ______

Vision Plan Enrollment Form

Organization Name:____

I. Check the Appropriate Boxes

Coverage Desired

- ☐ Employee Only $_____
- ☐ Employee + One $_____
- ☐ Employee + Family $_____

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

EFFECTIVE DATE: _______________

REASON FOR CHANGE IN STATUS

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

II. Employee Information (please print clearly):

Social Security Number _____ - _____ - _____ Birth Date _____/ _____/ _____ Home Phone (_____) _____ - _____ Work Phone (_____) ______- _____-_____

Your Name:____
(First) (Middle Initial) (Last)

Address ____
(City) (State) (Zip)

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

	First Name Last Name	Birth Date	Full Time Student?	Gender
Spouse	______________________	____/____/____	not applicable	☐M / ☐F
Child	______________________	____/____/____	☐ Yes ☐ No	☐M / ☐F
Child	______________________	____/____/____	☐ Yes ☐ No	☐M / ☐F
Child	______________________	____/____/____	☐ Yes ☐ No	☐M / ☐F
Child	______________________	____/____/____	☐ Yes ☐ No	☐M / ☐F

I agree to continue enrollment in the vision plan for a period of 12 months. I authorize on behalf of myself and anyone added to this application ("US") the use of a Social Security Number for purpose of identification. The information provided on this application is accurate and complete to the best of my knowledge and belief. I understand and agree that any omissions or incorrect statements knowingly made by US on this application may invalidate my and /or my dependents' coverage.

Florida Residents Only: NOTICE: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

*Your Signature*____ *Date*_________________

Spectera Inc. provides insured vision coverage underwritten by UnitedHealthCare Insurance Company (except NY) and United HealthCare Insurance Company of New York (NY only)

2003 – EF3t