SPECTERA
A UnitedHealth Group Company
Baltimore, MD

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	☐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.

*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.