SPECTERA®

A UnitedHealth Group Company

Vision Plan Enrollment Form

TO BE COMPLETED BY GROUP BENEFITS OFFICE:

Effective Date: ____/_____/_____

Group # _____

Plan Variation Vision _____

Reporting Code Vision _____

Organization Name: VANDERBURGH COUNTY

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