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: ____

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

EFFECTIVE DATE: ____________

REASON FOR CHANGE IN STATUS

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

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)

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