SPECTERA®

A UnitedHealth Group Company

**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 + 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 provides services under the following regulated subsidiaries in the following states: Spectera Vision Inc.; Maryland - Spectera Insurance Company

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