SPECTERA

A Underwritten Group Company

Baltimore, MD

TO BE COMPLETED BY BENEFITS OFFICE:

Effective Date: ____/____/_____

Client Code: _____ Sub Code _____

G/L Number _____

Vision Plan Enrollment Form

Organization Name: _____

I. Check the Appropriate Boxes

Coverage Desired:

12 months

☐ Employee Only $8.38

☐ Employee + One $14.51

☐ Employee + Family $24.47

9 months

☐ Employee Only $11.17

☐ Employee + One $19.35

☐ Employee + Family $32.63

☐ New Enrollment

☐ Change of Status/Address

☐ Open Enrollment

☐ COBRA

Reason For Change In Status:

☐Termination

☐Death

☐Marriage

☐Divorce

☐Newborn Child

☐Last Name/Address Change

☐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 # _____-_____-_____

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* _____

Spectera, Inc. administers vision benefits underwritten by the following entities: United HealthCare Insurance Company (except NY) and United HealthCare Insurance Company of New York, (NY only).

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