UnitedHealthcare Vision℠

TO BE COMPLETED BY GROUP BENEFITS OFFICE:
Effective Date: _____/_____/_____
Group # _____
Plan Variation Vision _____
Reporting Code Vision _____

# Vision Plan Enrollment Form

**Organization Name:** _____

## 1. Check the Appropriate Boxes

**Coverage Desired**
- ☐ Employee Only $ _____
- ☐ Employee + Family $ _____

- ☐ New Enrollment
- ☐ Change of Status/Address
- ☐ Open Enrollment
- ☐ COBRA

EFFECTIVE DATE: _____

REASON FOR CHANGE IN STATUS
- ☐ Termination
- ☐ Newborn Child
- ☐ Adoption/legal custody
- ☐ Dependent child married/ reached age limit
- ☐ Death
- ☐ Last Name
- ☐ Marriage
- ☐ Other Insurance
- ☐ Legal custody of parent
- ☐ Divorce
- ☐ Move to COBRA

## 2. Employee Information (please print clearly):

Social Security Number _____-_____-_____ Birth Date _____/_____/_____ Home Phone (_____)_____-_____ Work Phone (_____)_____-_____

Your Name: _____
(First) (Middle Initial) (Last)

Address: _____
(City) (State) (Zip)

## 3. 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 |
| 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_____

UnitedHealthcare Vision is underwritten by United HealthCare Insurance Company (except NY) and United HealthCare Insurance Company of New York (NY only)
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