UnitedHealthcare Vision℠

TO BE COMPLETED BY BENEFITS OFFICE:
Effective Date: _____/_____/_____
Sub Code: _____ Client Code: A950
G/L Account: _____

Vision Plan Enrollment Form

Organization Name: Troup County Board of Commissioners

I. Check the Appropriate Boxes

Coverage Desired **Bi-Weekly Rate**

☐ Employee Only **$3.47**

☐ Employee + Family **$9.12**

☐ New Enrollment

☐ Change of Status/Address

☐ Open Enrollment

☐ COBRA

REASON FOR CHANGE IN STATUS

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

II. Employee Information (please print clearly):

Unique Member ID Number _____ - _____ - _____

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).