

Organization Name

Vision Plan Enrollment Form

VANDERBURGH COUNTY

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 + One Employee + Family II. Employee Information (please print clearly)	☐ New Enrollment ☐ Change of Status/Address ☐ Open Enrollment ☐ COBRA EFFECTIVE DATE:	☐ Adoption/legal custody of child☐ Dependent child married/reached a	: Name	COBRA
	Birth Date//	Home Phone ()	Work Phone ()	_
Address(City)		(State)	(Zip)	
III. List All Eligible Family Members Below (if e		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)