

Voluntary Vision Enrollment Form

Group Voluntary Vision Coverage Provided
by UHIC in partnership with Spectera Vision

cbg | **CONFIDENT**

SOCIAL SECURITY NUMBER		EMPLOYEE ID NUMBER (if different than SSN)		DATE : / /	
LAST NAME			FIRST NAME		MI
ADDRESS			CITY	STATE	ZIP
TELEPHONE NUMBER HOME () WORK ()				<input type="checkbox"/> Male <input type="checkbox"/> Single	<input type="checkbox"/> Female <input type="checkbox"/> Married
APPLICANTS DATE OF BIRTH		EMPLOYER OR GROUP NAME			
PLAN COVERAGE <input type="checkbox"/> Employee \$7.08 <input type="checkbox"/> Employee + Spouse (or Domestic Partner) \$13.43 <input type="checkbox"/> Employee + Child(ren) \$14.11 <input type="checkbox"/> Family \$21.69					

INFORMATION FOR DEPENDENT COVERAGE

Spouse & Unmarried Dependent Children Only (Include Date of Birth)

First Name	Initial	Last Name (if different)	Date of Birth (Mo/Day/Yr)	Relationship		If Child is over 19, please indicate status and school		
				<input type="checkbox"/> Wife <input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Husband <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student at: _____	<input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel
				<input type="checkbox"/> Son	<input type="checkbox"/> Daughter <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student at: _____	<input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel
				<input type="checkbox"/> Son	<input type="checkbox"/> Daughter <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student at: _____	<input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel
				<input type="checkbox"/> Son	<input type="checkbox"/> Daughter <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student at: _____	<input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel
				<input type="checkbox"/> Son	<input type="checkbox"/> Daughter <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student at: _____	<input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel

*For court ordered dependent, legal documentation must be attached. Please see employer representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible employee, please provide address on separate sheet.

FOR INTERNAL USE ONLY

EMPLOYER or GROUP AUTHORIZATION
EFFECTIVE DATE

SIGNATURE _____
I understand that any coverage is limited by the benefits and exclusions of the Group Voluntary Vision Agreement

MINIMUM ENROLLMENT IS FOR ONE YEAR

CONFIDENTSM by cbg in partnership with Spectera Vision Plans are underwritten by United HealthCare Insurance Company, Hartford, Connecticut (except in New York), United HealthCare Insurance Company of New York; Hauppauge, New York (New York Only).