

UnitedHealthcare VisionSM

TO BE COMPLETED BY BENEFITS OFFICE:
 (ALL must be included for processing)

Effective Date: ____/____/____
 Reporting Code : _____
 Group#: 755697

Organization Name: City of Worcester

I. Check the Appropriate Boxes

Coverage Desired		REASON FOR CHANGE IN STATUS	
<input type="checkbox"/> Employee Only	\$ 5.36	<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Termination
<input type="checkbox"/> Employee + One	\$10.72	<input type="checkbox"/> Change of Status/Address	<input type="checkbox"/> Marriage
<input type="checkbox"/> Employee + Family	\$16.08	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Newborn Child
		<input type="checkbox"/> COBRA	<input type="checkbox"/> Other Insurance
			<input type="checkbox"/> Move to COBRA
			<input type="checkbox"/> Death
			<input type="checkbox"/> Divorce
			<input type="checkbox"/> Last Name/Address Change
			<input type="checkbox"/> Adoption/legal custody of child
			<input type="checkbox"/> Legal custody of parent
			<input type="checkbox"/> Dependent child married/reached age limit

II. Employee Information (please print clearly):

Social Security Number ____ - ____ - ____ Birth Date ____/____/____

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

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?	Gender
Spouse	_____	_____	____/____/____	not applicable	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> 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.

Employee Signature _____ Date _____

Employer Signature _____ Date _____

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