

UnitedHealthcare VisionSM

TO BE COMPLETED BY BENEFITS OFFICE:

Effective Date: ____/____/____

Policy# : 755697

Group#: 1000_

Organization Name: City of Worcester

I. Check the Appropriate Boxes

Coverage Desired

- Employee Only \$ 5.21
- Employee + One \$10.42
- Employee + Family \$15.64

- 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):

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).