UnitedHealthcare Vision℠

TO BE COMPLETED BY BENEFITS OFFICE:
Effective Date: _____/_____/_____
Sub Code: Client Code: **F3R4**
G/L Account: **238490**

Vision Plan Enrollment Form

Organization Name: **Darien Public Schools**

I. Check the Appropriate Boxes

Coverage Desired

- ☐ Employee Only
- ☐ Employee + 1
- ☐ Employee + Family
- ☐ I choose not to enroll in the vision plan

- ☐ New Enrollment
- ☐ Change of Status/Address
- ☐ Open Enrollment
- ☐ COBRA

Effective Date: _____

REASON FOR CHANGE IN STATUS

- ☐ Termination
- ☐ Marriage
- ☐ Newborn Child
- ☐ Other Insurance
- ☐ Move to COBRA
- ☐ Death
- ☐ Divorce
- ☐ Last Name
- ☐ 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, United HealthCare Insurance Company of New York, Unimerica Insurance Co., Inc., and American General Assurance Company.