

Vision Plan Enrollment Form

Organization Name: **Diocese of Gary**

Plan Year 2010 - 2011

I. Check the Appropriate Boxes

Coverage Desired

- Employee Only \$10.00
- Employee + Spouse \$16.00
- Employee + Child(ren) \$17.00
- Employee + Family \$26.00

- New Enrollment
- Change of Status/Address
- Open Enrollment
- COBRA
- Cancel employee
- Cancel dependent(s)

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):

Unique Member ID Number ____ - ____ - ____ (SSN)

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	<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

Your Signature _____ Date _____

Spectera, Inc. administers vision benefits underwritten by the following entities United HealthCare Insurance Company (except NY) and United HealthCare Insurance Company of New York (NY only).