UNITED HEALTHCARE VISION INSURANCE

Vision Enrollment Change Form

Employer: VANDERBURGH COUNTY _______ 206649

Employee's Name ____________________

Employee's Date of Birth ____ / ____ / ____ Social Security No. ____ - ____ - ____

Employee's Address: ____________________

____

Change effective as of ____ / ____ / ____

Check all changes that apply:

- ☐ Cancel Coverage (Employee Terminated) ☐ COBRA
- ☐ Address Change - New Address ____________________

  ____
- ☐ Name Change - New Name ____________________
- ☐ Add Dependents (complete chart below)
- ☐ Delete Dependents (complete chart below)
- ☐ Other: ____________________

Add	Delete	Name	Birth Date	Sex	Relationship	Reason

Employee's Signature ____________________ Date ____ / ____ / ____

Employer's Signature ____________________ Date ____ / ____ / ____

Mail or Fax this form to:

UNITED HEALTHCARE VISION
2811 Lord Baltimore Drive
Baltimore, Maryland 21244-2644
Attention : Eligibility Department

Telephone Number: (410) 265-6033 or (800) 638-3895

Fax Number: (410) 265-6049

Note: Changes must be received by the 15th of the month to be reflected on your next invoice.

Change.doc - 04/18/00