



Vision Plan Enrollment Form

Organization Name: Vanderburgh County 2-06649

I. Check the Appropriate Boxes

Coverage Desired

- Employee Only
- Employee + One
- Employee + Family

- 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):

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	<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, United HealthCare Insurance Company of New York, Unimerica Insurance Co., Inc., and American General Assurance Company.