

Vision Plan Enrollment Form

Organization Name: Roosevelt University

I. Check the Appropriate Boxes

Coverage Desired		REASON FOR CHANGE IN STATUS	
<input type="checkbox"/> Employee Only	\$6.77	<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Termination
<input type="checkbox"/> Employee + Spouse	\$12.91	<input type="checkbox"/> Change of Status/Address	<input type="checkbox"/> Marriage
<input type="checkbox"/> Employee + Child(ren)	\$13.49	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Newborn Child
<input type="checkbox"/> Employee + Family	\$20.76	<input type="checkbox"/> COBRA	<input type="checkbox"/> Other Insurance
			<input type="checkbox"/> Move to COBRA
			<input type="checkbox"/> Death
			<input type="checkbox"/> Divorce
			<input type="checkbox"/> Last Name/Address Change
			<input type="checkbox"/> Adoption/legal custody of child
			<input type="checkbox"/> Legal custody of parent
			<input type="checkbox"/> Dependent child married/reached age limit

II. Employee Information (please print clearly):

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 (except NY) and United HealthCare Insurance Company of New York (NY only).