Supplemental Benefits Interest Form

Must enroll 30 days from first day of work

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Email this form to: cobbenrollment@houze.org

(Note: Completing this form doesn't enroll benefits)

Name	Gender	☐ Married ☐ Single	Birth Date	Hire Date
Address		Social Security Number		Employee ID
City State Zip		Department		Earnings
Work Phone	Best Tim to Call	Shift Time	Effective Date	
Cell Phone	Email Address			

I AM INTERESTED IN INFORMATION ON:

☐	**Vision Insurance-** *complete the enrollment form see reverse, return to Aflac Rep*	UnitedHealthcare	Employee & Family Coverage Available
☐	**Legal Insurance-** *must enroll with Aflac Rep*	MetLife	High & Low Option Coverage Available
☐	**Short Term Disability-** *must enroll with Aflac Rep*	Aflac	Income Protection
☐	**Cancer Insurance-** *must enroll with Aflac Rep*	Aflac	Family Coverage Available
☐	**Accident Insurance-** *must enroll with Aflac Rep*	Aflac	Family Coverage Available
☐	**Hospital Indemnity-** *must enroll with Aflac Rep*	Aflac	Family Coverage Available
☐	**Critical Care Protection-** *must enroll with Aflac Rep*	Aflac	Family Coverage Available
☐	**Pet Health Insurance-** *call 855-270-7387 Cobb Code 21000*	MetLife	Discounts available as a Cobb Employee
☐	**Part- Time Dental-** *must enroll with Aflac Rep*	United Concordia Insuring America's Dental Health	Employee & Family Coverage Available

UnitedHealthcare Vision℠

TO BE COMPLETED BY BENEFITS OFFICE:
Effective Date: _____/_____/_____
Sub Code: _____ Client Code :3161
G/L Account: _____

Vision Plan Enrollment Form

Organization Name: Cobb County Government

I. Check the Appropriate Boxes

Rate Biweekly		
☐ Employee Only	$3.85	☐ New Enrollment
☐ Employee + Family	$8.94	☐ Change of Status/Address
		☐ Open Enrollment
		☐ COBRA

REASON FOR CHANGE IN STATUS must also notify UHC for Qualify Event Change.

- ☐ Termination
- ☐ Marriage
- ☐ Newborn Child
- ☐ Other Insurance
- ☐ Death
- ☐ Divorce
- ☐ Last Name/Address change
- ☐ Move to COBRA
- ☐ 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 _____ Date of Hire _____

Your Name _____
(First) (Middle Initial) (Last)

Birth Date ___/___/___ Social Security Number _____

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

Form Must be Submitted within 30 days of your start date.

*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).

Return completed form to cobbenrollment@houze.org to enroll