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