| TO BE COMPLETED BY BENEFITS OFFICE: |
|---|
| Effective Date: |
| Group#: |
| Plan Variation Vision: |
| Reporting Code Vision: |

UnitedHealthcare® Vision™

# Vision Plan Enrollment Form

Organization Name: Norridge School District 80

## I. Check the Appropriate Boxes

**Coverage Desired**

- ☐ Employee Only $5.88
- ☐ Employee + One $10.30
- ☐ Employee + Family $17.77

HIRE DATE _____

- ☐ New Enrollment
- ☐ Change of Status/Address
- ☐ Open Enrollment
- ☐ COBRA
- ☐ Cancel Coverage

EFFECTIVE DATE: _____

**REASON FOR CHANGE IN STATUS**

- ☐ Termination
- ☐ Death
- ☐ Marriage
- ☐ Divorce
- ☐ Newborn Child
- ☐ Last Name/Address Change
- ☐ Other Insurance
- ☐ 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 ____ - ____ - _____ Birth Date ____/____/_____ Home Phone (____) ____ - ____ Work Phone (____) ____ - ____ Gender ☐ M / ☐ F

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

Address _____

_____
(City) (State) (Zip) _____

## III. List All Eligible Family Members Below (if electing dependent coverage):

| | First Name | Last Name | Birth Date | Full Time Student? | Gender |
|---|---|---|---|---|---|
| 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 |

*I agree to continue enrollment in the vision plan for a period of 12 months. I authorize on behalf of myself and anyone added to this application ("US") the use of a Social Security Number for purpose of identification. The information provided on this application is accurate and complete to the best of my knowledge and belief. I understand and agree that any omissions or incorrect statements knowingly made by US on this application may invalidate my and/or my dependents' coverage.*

***Florida Residents Only: NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.***

*Your Signature* _____ *Date* _____