Voluntary Vision Enrollment Form

Group Voluntary Vision Coverage Provided
by UHIC in partnerhsip with Spectera Vision

cbg | CONFIDENT

SOCIAL SECURITY NUMBER	EMPLOYEE ID NUMBER (if different than SSN)	DATE : / /

LAST NAME	FIRST NAME	MI

ADDRESS	CITY	STATE	ZIP

TELEPHONE NUMBER HOME ( ) WORK ( )	☐ Male	☐ Female
	☐ Single	☐ Married

APPLICANTS DATE OF BIRTH	EMPLOYER OR GROUP NAME

PLAN COVERAGE ☐ Employee $7.08 ☐ Employee + Spouse (or Domestic Partner) $13.43 ☐ Employee + Child(ren) $14.11 ☐ Family $21.69

INFORMATION FOR DEPENDENT COVERAGE

Spouse & Unmarried Dependent Children Only (Include Date of Birth)

First Name Initial Last Name (if different)	Date of Birth (Mo/Day/Yr)	Relationship			If Child is over 19, please indicate status and school	
		☐ Wife ☐ Husband ☐ Domestic Partner		☐ M ☐ F	☐ Student at: ______ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel
		☐ Son	☐ Daughter	☐ M ☐ F	☐ Student at: ______ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel
		☐ Son	☐ Daughter	☐ M ☐ F	☐ Student at: ______ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel
		☐ Son	☐ Daughter	☐ M ☐ F	☐ Student at: ______ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel
		☐ Son	☐ Daughter	☐ M ☐ F	☐ Student at: ______ ☐ Handicapped	☐ Enroll ☐ Change ☐ Cancel

*For court ordered dependent, legal documentation must be attached. Please see employer representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible employee, please provide address on separate sheet**.**

FOR INTERNAL USE ONLY

EMPLOYER or GROUP AUTHORIZATION
EFFECTIVE DATE

SIGNATURE ____

I understand that any coverage is limited by the benefits and exclusions of the Group Voluntary Vision Agreement

MINIMUM ENROLLMENT IS FOR ONE YEAR

CONFIDENT[SM] by cbg in partnership with Spectera Vision Plans are underwritten by United HealthCare Insurance Company, Hartford, Connecticut (except in New York), United HealthCare Insurance Company of New York; Hauppauge, New York (New York Only).