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 ☐ Single	☐ Female ☐ 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 ☐ Domestic Partner	☐ Husband	☐ 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).