Enrollment Form

Group Vision Care Insurance

Provided by United HealthCare Insurance Company

Check the Appropriate Boxes

Requested Effective Date of Coverage / Date of Change: / / ☐ Enroll ☐ Cancel ☐ Change

Reason: ☐ New Group Plan ☐ New Hire ☐ Annual Open Enrollment ☐ Address Change ☐ Name Change ☐ Employee Terminated ☐ Marriage ☐ Divorce ☐ Death ☐ Birth ☐ Adoption/Legal Custody ☐ Court ordered Dependent ☐ Dependent married/reached age limit ☐ Cobra/State Continuation ☐ Other:

Employee Information

Social Security Number: - -	Date of Birth: / /	
Last Name:	First Name:	Middle Initial:
Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	Email Address:
Sex: ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	

Coverage Selection

Plan Coverage: ☐ Employee Only ☐ Employee + Spouse (or Domestic Partner*) ☐ Employee + Child(ren) ☐ Family

Family Information

Dependents to be enrolled, cancelled, changed: (Attach additional sheet if necessary)

Check Appropriate Box	First Name MI Last Name (if different) / Dependent Social Security Number	Date of Birth	Sex	Relationship**	Full-time Student
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	/ /	☐ M ☐ F	☐ Spouse ☐ Domestic Partner*	Not Applicable
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	/ /	☐ M ☐ F	Dependent	☐ Yes ☐ No School Name:
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	/ /	☐ M ☐ F	Dependent	☐ Yes ☐ No School Name:
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	/ /	☐ M ☐ F	Dependent	☐ Yes ☐ No School Name:
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	/ /	☐ M ☐ F	Dependent	☐ Yes ☐ No School Name:

*Domestic Partner coverage is determined by your Employer. Please confirm coverage for Domestic Partners with your Employer.

**For court ordered Dependent(s), legal documentation must be attached. Please see an Employer representative for more information about the qualifications for full-time student status. If Dependent(s) does not reside with enrollee, please provide address on separate sheet.

Other Vision Coverage Information

On the day this coverage begins, will you, your spouse (or domestic partner*), or any of your dependents be covered under any other vision care insurance plan or policy including another United HealthCare Insurance Company vision care insurance plan or Medicare?
☐ Yes ☐ No

Spouse (or Domestic Partner*) Name:	Name of other Carrier:
Dependent Name:	Name of other Carrier:
Dependent Name:	Name of other Carrier:
Dependent Name:	Name of other Carrier:

*Domestic Partner coverage is determined by your Employer. Please confirm coverage for Domestic Partners with your Employer.

Employee/Applicant Signature
(form must be signed)

I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued.

I understand that the vision care insurance benefit plan I have selected provides reimbursement for certain vision costs which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my provider or me for vision care expenses which I have incurred may not be covered by my vision care insurance benefit plan.

The Certificate provides vision care insurance benefits only. Review your Certificate carefully.

FRAUD WARNING NOTICE{S}: {(Please review the notice that applies in your state.)}

{For applicants in {Arkansas} {and} {West Virginia}:
Any person who knowingly presents a false or fraudulent claim for payment of a los or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.}

{For applicants in Colorado:
It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.}

{For applicants in District of Columbia:
WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.}

{For applicants in Hawaii:
For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.}

{For applicants in Kentucky:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.}

{For applicants in Louisiana:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.}

{For applicants in New Jersey:
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.}

{For applicants in New Mexico:
ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.}

{For applicants in Ohio:
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.}

{For applicants in Oklahoma:
Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.}

{For applicants in Oregon:
Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.}

{For applicants in the state of Pennsylvania:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.}

{For applicants in all other states:
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.}

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

Employee/Applicant Signature:	Date: / /

To Be Completed by Employer

Employer Name:			Enrollee Effective Date: / /	Class Code:
Enrollment: ☐ New Hire ☐ Other	Date of Hire: / /	Policy Number:	Plan Variation/ Reporting Code:	Plan Code:
Employer Authorization:				

Group vision care insurance products are underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut.