UnitedHealthcare Vision ™

TO BE COMPLETED BY GROUP BENEFITS OFFICE:
Effective Date: _____/_____/_____
Group # _____
Plan Variation Vision _____
Reporting Code Vision _____

Vision Plan Enrollment Form

Organization Name: Burbank Management Association

1. Check the Appropriate Boxes

Coverage Desired
☐Employee Only $_____
☐Employee + Family $_____

☐New Enrollment
☐Change of Status/Address
☐Open Enrollment
☐COBRA
DATE W/BMA: _____

REASON FOR CHANGE IN STATUS
☐Termination ☐Death ☐Legal Custody of Parent
☐Newborn Child ☐Last Name ☐Divorce
☐Adoption/legal custody ☐Marriage ☐Move to COBRA
☐Dependent child married/reached age limit ☐Other Insurance

2. Employee Information (Please print clearly):

Social Security Number _____-_____-_____ Birth Date _____/_____/_____ Gender: M / F Home Phone (_____)_____-_____ Work Phone (_____)_____-_____

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

Address: _____
(Street) (City) (State) (Zip)

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

	First Name	Last Name	Social Security Number	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 PERSONS 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.

Your Signature _____ Date _____
UnitedHealthcare Vision is underwritten by United HealthCare Insurance Company (except NY) and United HealthCare Insurance Company of New York (NY only)