OptumHealth℠ Vision

Effective Date: _1_ / _1_ / _2009

Agency : _____

Vision Plan Enrollment Form
State of Wisconsin Employees

I. Check the Appropriate Boxes

Coverage Desired (all rates are monthly)

- ☐ Employee Only $ 5.83
- ☐ Employee + Spouse $11.34
- ☐ Employee + Child(ren) $11.88
- ☐ Employee + Family $17.82
- ☐ Opt Out $_0.00

REASON FOR COVERAGE SELECTED

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

REASON FOR CHANGE IN STATUS

- ☐ Termination
- ☐ Death
- ☐ Marriage
- ☐ Divorce
- ☐ Newborn Child
- ☐ Other Insurance
- ☐ Move to COBRA
- ☐ Last Name/Address Change
- ☐ Adoption/legal custody of child
- ☐ Legal custody of parent

II. Employee Information (please print clearly):

Unique Member ID Number _____ - _____ - _____

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

Birth Date _____/ _____/ _____

Address _____

_____

Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

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

	First Name	Last Name	Birth Date	Full Time Student?	Sex
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 through December 31, 2009 and authorize you to deduct premiums from my payroll for vision care services in future periods. To cancel my coverage, I must submit a request for cancellation prior to December 1 of the current year to cancel coverage beginning January 1 of the following year.

*Your Signature*_____ *Date*_____

Spectera provides services under the following regulated subsidiaries in the following states: Spectera Vision Inc.; Maryland - Spectera Insurance Company