



# Vision Plan Enrollment Form State of Wisconsin Retirees

Effective Date: January 1, 2009  
Group #: GIHA

To **add new coverage**, **change coverage** or **opt out** of vision care through OptumHealth, complete this form and mail before **November 14th** to: UnitedHealthcare Specialty Benefits, ATTN: Navnit Chitalia, Liberty 6, Suite 200, 6220 Old Dobbin Lane, Columbia, MD 21045, or fax to: 888-574-7335.

**If you already have coverage and wish to continue coverage with no changes, you do not need to complete this form.**

## I. Check the Appropriate Box --- The Rates Listed Below are Per Month ---

- Retiree Only      \$ 5.83                       Retiree + Spouse    \$11.34                       Opt Out    \$ 0.00
- Retiree + Children    \$11.88                       Retiree + Family    \$17.82

## II. Retiree Information (please print clearly):

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Your Name \_\_\_\_\_  
(First)                                      (Middle Initial)                                      (Last)

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

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

	First Name	Last Name	Birth Date	Full Time Student?	Gender
Spouse	_____	_____	____/____/____	not applicable	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M / <input type="checkbox"/> F

*I agree to continue enrollment in the vision plan for a period of 12 months and authorize you to deduct monthly premiums from my Wisconsin Retirement System benefit checks. I know renewals for this coverage will be on a 12 month cycle and I cannot change family status or drop this coverage until the 12-month cycle expiration (December 31, 2009).*

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

**Florida Residents Only: NOTICE: 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.**