

Vision Plan Enrollment Form 2008-2009

Organization Name: Washington Teachers Union Local #6

I. Check the Appropriate Boxes

| Coverage Desired | | REASON FOR CHANGE IN STATUS | |
|--|----------|---|--|
| <input type="checkbox"/> Employee Only | \$0.00 | <input type="checkbox"/> New Enrollment | <input type="checkbox"/> Termination |
| <input type="checkbox"/> Employee + Family | \$0.00 | <input type="checkbox"/> Change of Status/Address | <input type="checkbox"/> Marriage |
| <input type="checkbox"/> Retiree | \$140.40 | <input type="checkbox"/> Open Enrollment | <input type="checkbox"/> Newborn Child |
| | | <input type="checkbox"/> COBRA | <input type="checkbox"/> Other Insurance |
| | | | <input type="checkbox"/> Move to COBRA |
| | | | <input type="checkbox"/> Death |
| | | | <input type="checkbox"/> Divorce |
| | | | <input type="checkbox"/> Last Name |
| | | | <input type="checkbox"/> Adoption/legal custody of child |
| | | | <input type="checkbox"/> Legal custody of parent |
| | | | <input type="checkbox"/> Dependent child married/reached age limit |

II. Employee Information (please print clearly):

Social Security 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 | <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 |

Student Verification Form must be attached for Full Time College Students (19-23 years old)

I agree to continue enrollment in the vision plan for a period of 12 months

Your Signature _____ Date _____

Spectera, Inc. administers vision benefits underwritten by the following entities United HealthCare Insurance Company (except NY) and United HealthCare Insurance Company of New York (NY only).