UNICARE®
A Healthy Dose of Innovation®

VISION ENROLLMENT FORM

WORKSHEET INSTRUCTIONS

— PLEASE PRINT —

Section 1 Employee Information
Please fill in requested information

Section 2 Member Information
Please fill in requested information
Please check the appropriate boxes

Section 3 Dependent Information
Please fill in requested information
Please check the appropriate boxes

Section 4 Coverage Election
Please fill in requested information
Please check the appropriate box

Section 5 Employee Authorization
Please sign, date, and return form

UNICARE Copy - Send white copy to UNICARE for processing

Employee Copy - Retain the yellow copy for your records

Employer Copy - Retain the pink copy for your records

Reset

UNICARE®
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Vision Only Enrollment Form

Type of Enrollment

❒ New enrollee	❒ COBRA	❒ Re-enrollee

1. *Employee Information*

NAME OF POLICY HOLDER (Employer)	
POLICY / CASE NUMBER (if applicable)	EFFECTIVE DATE

2. *Member Information*

EMPLOYEE NAME	DATE OF HIRE (Mo/Day/Yr)	
HOME ADDRESS		
CITY, STATE, ZIP	EMPLOYMENT STATUS ❒ Active ❒ Retired ❒ COBRA	COBRA EFFECTIVE DATE (Mo/Day/Yr)
DO YOU WANT COVERAGE FOR: Spouse ❒ Yes ❒ No	DO YOU WANT COVERAGE FOR: DEPENDENT CHILDREN ❒ Yes ❒ No	ORIGINAL COBRA EFFECTIVE DATE (Mo/Day/Yr)

3. *Dependent Information (To elect dependent coverage, the corresponding employee coverage must be elected)*

Name (First, MI, Last)	Relationship	Sex M-Male F-Female	Date of Birth (Mo/Day/Yr)	Full-time Student (if age 19 or older)	Social Security Number
	Employee	❒ M ❒ F			
	Spouse	❒ M ❒ F			
	Child	❒ M ❒ F		❒ Yes ❒ No	
	Child	❒ M ❒ F		❒ Yes ❒ No	
	Child	❒ M ❒ F		❒ Yes ❒ No	
	Child	❒ M ❒ F		❒ Yes ❒ No	
	Child	❒ M ❒ F		❒ Yes ❒ No	

4. *Coverage Election*

❒ Check here if you are declining vision coverage.

5. Employee Authorization

I hereby apply for the insurance for which I am now or may become eligible under the group policy or policies issued to the policyholder by UniCare Life & Health Insurance Company. I hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such insurance, which authorization may be revoked by me at any time by prior written notice to the policyholder. I understand that if my employment is terminated, upon re-employment, insurance will not become effective until I again apply for insurance in accordance with the terms of the group policy. To the best of my knowledge and belief, the information I have provided on this form is complete and correct.

I authorize payment of vision benefits to preferred providers, where applicable, for those charges covered by my group insurance benefits. I authorize any educational institution to furnish my employer or insurance carrier with information necessary to establish student eligibility. These authorizations shall remain valid during my term of coverage under my group insurance plan or 30 months, whichever is less. I or my authorized representative may request a copy of this authorization and a photocopy of this authorization shall be considered valid.

If you decline vision coverage, and you wish to apply for these coverages at a future date, you will have to comply with the rules governing late applicants.

EMPLOYEE'S SIGNATURE	**DATE**

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4/04