

TO BE COMPLETED BY BENEFITS OFFICE:  
 Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Sub Code: \_\_\_\_\_ Client Code: \_\_\_\_\_  
 G/L Account: \_\_\_\_\_

### Vision Plan Enrollment Form

Organization Name: **GEORGIA INSTITUTE OF TECHNOLOGY – Client Code: A437**

**I. Check the Appropriate Boxes**

<b>Coverage Desired</b>		<b>REASON FOR CHANGE IN STATUS</b>	
<input type="checkbox"/> Employee Only \$ 7.06	<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Termination	<input type="checkbox"/> Death
<input type="checkbox"/> Employee + Spouse \$13.58	<input type="checkbox"/> Change of Status/Address	<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce
<input type="checkbox"/> Employee + Child(ren) \$14.24	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Newborn Child	<input type="checkbox"/> Last Name/Address Change
<input type="checkbox"/> Employee + Family \$21.62	<input type="checkbox"/> COBRA	<input type="checkbox"/> Other Insurance	<input type="checkbox"/> Adoption/legal custody of child
		<input type="checkbox"/> Move to COBRA	<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

I agree to continue enrollment in the vision plan for a period of 12 months  
 Your Signature \_\_\_\_\_ Date \_\_\_\_\_

I decline to enroll in the vision plan at this time  
 Your Signature \_\_\_\_\_ Date \_\_\_\_\_

Spectera, Inc. administers vision benefits underwritten by the following entities: United HealthCare Insurance Company, United HealthCare Insurance Company of New York, Unimerica Insurance Co., Inc., and American General Assurance Company.