ENROLLMENT / CHANGE FORM FOR GROUP VISION CARE INSURANCE
Opticare of Utah
1901 West Parkway Blvd., Salt Lake, City, UT 84119
800-363-0950 (www.opticareofutah.com)

The Certificate Provides Vision Coverage Only.

Please print all answers

Name of Employer:	Hire Date
New Enrollment Effective Date _____	Termination of Employment Effective Date _____ HR Manager Signature
Change in Coverage Effective Date _____	Cobra Effective Date _____
Life change event causing change in coverage:	

1. Employee

Employee Name (First/Middle/Last):		E-mail Address: (optional)
Home Address - Street:	City:	State & Zip Code:
Social Security Number:	Date of Birth (Mo./Day/Yr):	Home Phone Number:

2. Dependents (Indicate the names, social security numbers and date of birth for all dependents to be insured under the policy.)

Name	Social Security Number	Date of Birth	Add	Drop
Spouse:				
Child:				
Child:				
Child:				
Child:				
Child:				
Child:				

3. Benefit Selection - Employee must enroll and elect a plan in order for dependent(s) to be enrolled

Vision Plan Selected:

To the best of my knowledge and belief, the information I have provided on this form is correct. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits. I authorize and instruct my Employer to deduct from my pay each pay period the premium due for my vision insurance coverage, if required, purchased through *Opticare of Utah*. I understand that my enrollment under the group policy is for a 12-month period and that premiums must be paid for my enrollment for the entire 12-month period, except due to: (1) termination of employment with the employer; (2) death; (3) divorce; (4) election to disenroll during the employer's open enrollment period; or (5) other qualifying events. This authorization and assignment will remain in effect until revoked by me in writing to my Employer.

I have received, read and understand the outline of coverage for the vision benefit plan I have selected for coverage.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

_____ _____

Signature of Employee Date signed

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