

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

**Vision Plan Enrollment Form**

Organization Name: NorthAmerican Transportation Association Inc

**I. Check the Appropriate Boxes**

<b>Coverage Desired</b>		<b>REASON FOR CHANGE IN STATUS</b>	
<input type="checkbox"/> Employee Only \$_____	<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Termination	<input type="checkbox"/> Death
<input type="checkbox"/> Employee + One \$_____	<input type="checkbox"/> Change of Status/Address	<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce
<input type="checkbox"/> Employee + Family \$_____	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Newborn Child	<input type="checkbox"/> Last Name/Address Change
Effective Date _____	<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):**

Unique Member ID 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 \_\_\_\_\_

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.