



**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:				
<b>1. Employee</b>				
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:	
<b>2. Dependents</b> (Indicate the names, social security numbers and date of birth for all dependents to be insured under the policy.)				
<b>Name</b>	<b>Social Security Number</b>	<b>Date of Birth</b>	<b>Add</b>	<b>Drop</b>
Spouse:				
Child:				
<b>3. Benefit Selection - Employee must enroll and elect a plan in order for dependent(s) to be enrolled</b>				
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