UnitedHealthcare Vision

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

OPEN ENROLLMENT 2025-2026

Vision Plan Enrollment Form

Organization Name: Gloucester Township Board of Education

I. Check the Appropriate Boxes

Coverage Desired

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Employee + Family

- ☐ New Enrollment
- ☐ Change of Status/Address
- ☐ Open Enrollment
- ☐ COBRA
- ☐ Waive Benefit

REASON FOR CHANGE IN STATUS

- ☐ Termination
- ☐ Marriage
- ☐ Newborn Child
- ☐ Other Insurance
- ☐ Move to COBRA
- ☐ Death
- ☐ Divorce
- ☐ Last Name/Address Change
- ☐ Adoption/legal custody of child
- ☐ Legal custody of parent
- ☐ Dependent child married/ reached age limit

II. Employee Information (please print clearly):

Social Security Number _____ - _____ - _____

Date of Hire _____ - _____ - _____ Gender _____

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	SSN	Birth Date	Sex
Spouse					☐M / ☐F
Child					☐M / ☐F
Child					☐M / ☐F
Child					☐M / ☐F
Child					☐M / ☐F

Your Signature _____ *Date* _____