

UnitedHealthcare Vision

OPEN ENROLLMENT 2026-27

TO BE COMPLETED BY BENEFITS OFFICE:

Effective Date: ____/____/____

Client Code: ____ Sub Code: ____

G/L Number: _____

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 _____