SPECTERA
A UnitedHealth Group Company

UnitedHealthcare Dental®

Enrollment Form for Spectera Vision Benefits and UnitedHealthcare Dental® Benefits

SOCIAL SECURITY NUMBER	EMPLOYEE ID NUMBER (if available)	☐ New Enrollment ☐ Cancel ☐ Change in Status ☐ Open Enrollment Date of Change ____/____/____

REASON FOR CHANGE IN STATUS (if applicable) ☐ 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

LAST NAME	FIRST NAME	MI	ENROLLEE'S DATE OF BIRTH
ADDRESS	CITY	STATE	ZIP

TELEPHONE NUMBER
Home ( ) Work ( ) ☐ Male ☐ Female ☐ Single ☐ Married

DENTAL PLAN COVERAGE ☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

VISION PLAN COVERAGE ☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

INFORMATION FOR DEPENDENT COVERAGE

Spouse & Unmarried Dependent Children Only (Include Date of Birth)

First Name Initial Last Name (if different)	Date of Birth (Mo/Day/Yr)	Relationship**	If child is over age 19, please indicate status and school	
		☐ Wife ☐ M ☐ Husband ☐ F		**Dental:** ☐ Enroll ☐ Change ☐ Cancel ☐ Other Dental Insurance: ________ CARRIER NAME **Vision:** ☐ Enroll ☐ Change ☐ Cancel
		☐ Son ☐ M ☐ Daughter ☐ F	☐ Student at ________ ☐ Handicapped	**Dental:** ☐ Enroll ☐ Change ☐ Cancel ☐ Other Dental Insurance: ________ CARRIER NAME **Vision:** ☐ Enroll ☐ Change ☐ Cancel
		☐ Son ☐ M ☐ Daughter ☐ F	☐ Student at ________ ☐ Handicapped	**Dental:** ☐ Enroll ☐ Change ☐ Cancel ☐ Other Dental Insurance: ________ CARRIER NAME **Vision:** ☐ Enroll ☐ Change ☐ Cancel
		☐ Son ☐ M ☐ Daughter ☐ F	☐ Student at ________ ☐ Handicapped	**Dental:** ☐ Enroll ☐ Change ☐ Cancel ☐ Other Dental Insurance: ________ CARRIER NAME **Vision:** ☐ Enroll ☐ Change ☐ Cancel
		☐ Son ☐ M ☐ Daughter ☐ F	☐ Student at ________ ☐ Handicapped	**Dental:** ☐ Enroll ☐ Change ☐ Cancel ☐ Other Dental Insurance: ________ CARRIER NAME **Vision:** ☐ Enroll ☐ Change ☐ Cancel

**For court ordered dependent, legal documentation must be attached. Please see employer representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible employee, please provide address on separate sheet.

TO BE FILLED INTERNALLY

COMPANY NAME:			ENROLLEE EFFECTIVE DATE: (Mo/Day/Yr) ______/______/______
ENROLLMENT: ☐ New ☐ Other	POLICY NUMBER:	DENTAL PLAN VARIATION/REPORTING CODE:	DENTAL PLAN CODE:
	POLICY NUMBER:	VISION PLAN VARIATION/REPORTING CODE:	VISION PLAN CODE:
VISION CLIENT CODE:		VISION SUBCODE:	
AUTHORIZATION			

I confirm that the information I have provided on this form is complete and accurate.

I understand that the Dental and/or Vision benefit plan I have selected provides reimbursement for certain dental and/or vision costs which are more fully described in the current Certificates of Coverage or Summary Plan Descriptions. I understand there may be instances where treatment decisions made by my dentist, vision provider, or me, or dental or vision expenses which I have incurred may not be covered by my Dental and/or Vision benefit plan(s).

I understand that information collected in connection with administration of the benefit plan(s) may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee and may apply at the next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other dental coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

I agree to continue enrollment in the Dental and/or Vision plan(s) for a period of 12 months.

The Certificates provide dental and vision benefits only. Review your Certificates carefully.

SIGNATURE:______________________________ DATE:______________

UnitedHealthcare Dental insurance products are either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut (except in New York), or United HealthCare Insurance Company of New York, Hauppauge, New York (New York only). Spectera, Inc. administers vision benefits underwritten by United HealthCare Insurance Company and United HealthCare Insurance Company of New York.