Enrollment/Cancellation/Change Form

Group Vision Care Insurance provided by:

UNITEDHEALTHCARE INSURANCE COMPANY
185 Asylum St.
Hartford, CT 06103-3408

UnitedHealthcare®

Please Mail forms to:
HCEA
2107 Laurel Bush Rd. Ste. 201
Bel Air, MD 21015

ENROLLMENT INFORMATION

Employer Name: **HCEA MEMBER**	Date of Hire:
Requested Effective Date of Coverage / Date of Change:____/__/__	☐ New Hire Enrollment ☐ Annual Enrollment ☐ Cancellation ☐ Change
Reason for Change: (Check all that apply)	☐ Marriage ☐ Divorce ☐ Birth of Child ☐ Legal Adoption ☐ Other

PRODUCT SELECTION

Person	Vision	***Deduction per Pay***
Employee	☐ ☐ Waive	**$3.63 Employee Only**
Spouse (or Domestic Partner*)	☐ ☐ Waive	**$6.87 Employee & Spouse**
Dependent Child(ren)	☐ ☐ Waive	**$7.21 Employee & Children**
		$11.09 Employee & Family

EMPLOYEE INFORMATION

SS#_____-_____-_____	Employer Assigned ID#		Date of Birth: / /
Last Name:	First Name:		Middle Initial:
Address:	City:	State:	Zip Code:
Home Phone:	Work Phone:		Email Address:
Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Domestic Partner* ☐ Party to Civil Union *		

FAMILY INFORMATION

Dependents to be enrolled, cancelled, changed: (Attach additional sheet if necessary)

Check Appropriate Box	First Name MI Last Name (if different) / Dependent Social Security Number or Assigned ID	Date of Birth	Sex	Relationship**	Incapacitated***
☐ Enroll ☐ Change ☐ Cancel	SS#_____-_____-_____	__/ /_	☐ M ☐ F	☐ Spouse ☐ Domestic Partner* ☐ Civil Union*	Not Applicable
☐ Enroll ☐ Change ☐ Cancel	SS#_____-_____-_____	__/ /_	☐ M ☐ F	Dependent	☐ Yes ☐ No
☐ Enroll ☐ Change ☐ Cancel	SS#_____-_____-_____	__/ /_	☐ M ☐ F	Dependent	☐ Yes ☐ No
☐ Enroll ☐ Change ☐ Cancel	SS#_____-_____-_____	__/ /_	☐ M ☐ F	Dependent	☐ Yes ☐ No
☐ Enroll ☐ Change ☐ Cancel	SS#_____-_____-_____	__/ /_	☐ M ☐ F	Dependent	☐ Yes ☐ No

*Domestic Partner or Civil Union coverage is determined by state law or as determined by your employer. Please contact your employer for confirmation.

For court ordered Dependent(s), legal documentation must be attached. Please see an Employer representative for more information about the qualifications for full-time student status. If Dependent(s) does not reside with enrollee, please provide address on separate sheet. * Dependent is unmarried, financially dependent upon subscriber/covered person and is mentally or physically disabled. If answered "Yes" for Incapacitated, please attach medical certification of disability.

AUTHORIZATION AND ACKNOWLEDGEMENT

I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued.

If Vision product has been elected, I understand that the Vision benefit plan I have selected provides reimbursement for certain Vision costs which are more fully described in the current Certificates of Coverage. I understand there may be instances where treatment decisions made by my provider or me for Vision expenses which I have incurred may not be covered by my Vision benefit plan. The Certificates provide Vision benefits only. Review your Certificates carefully.

All statements made by me are: representations; and, not warranties. No statement made by me will be used to: contest the insurance provided by the Policy, unless, it is contained in a written statement signed by me; and, a copy of the statement is furnished to me or my beneficiary.

I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected. I acknowledge that I have read the applicable Fraud Warning Notices provided below.

FRAUD WARNING NOTICES: (Please review the notice that applies in your state.)

For residents of District of Columbia:
WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.

For residents of Maryland:
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey:
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of the state of Pennsylvania:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Virginia:
Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may have violated state law.

For residents of all other states:
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 is guilty of a crime and may be subject to fines and confinement in prison.

Employee/Enrollee Signature:	Date: / /